ADOLESCENT HEALTH: TIME FOR A CHANGE

Volume 1: Contractor Documents

1. "Child Welfare Services for Adolescents" by Margaret West, M.S.W., Ph.D. and Sally N. Stuart, M.S.W.
2. "Adolescent Victims of Maltreatment" by James Garbarino, Ph.D.

These contractor documents were prepared for the OTA assessment entitled ***Adolescent Health: Time For A Change***. They are being made available because they contain much useful information beyond that used in the OTA report. However, they are not endorsed by OTA, nor have they been reviewed by the Technology Assessment Board. References to them should cite the contractor, not OTA, as the author.

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CHILD WELFARE SERVICES FOR ADOLESCENTS

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Office of Technology Assessment's
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ADOLESCENTS IN THE CHILD WELFARE SYSTEM

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EXECUTIVE SUMMARY

The adolescents who are receiving services in the child welfare system have been described by Lisbeth Schorr in Within Our Reach as the "children of the shadows" and "adolescents with rotten outcomes". These youth have in most instances been involved in the child welfare system long before they reached adolescence. This paper summarizes available information about these youth in the traditional child welfare services of adoption, substitute care and child protection services as well as the more recently developed services of shelters and independent living programs.

At least one half of the children who received child welfare services in the most recent data available, 1985, were between the ages of ten to eighteen. These adolescents may be perceived as at a lower risk for physical harm from adults, perhaps less likely to respond to the available interventive services or sometimes as "getting what they deserve" or

"beyond help". These attitudes may present barriers to provision of services which are as great as the availability, accessibility or affordability of services. It appears that there are nearly equal numbers of males and females receiving child welfare services. Minority youth, especially blacks appear to be over represented in the child welfare system with some urban areas which are not predominantly minority reporting more than half of the youth in substitute care to be from minority groups.

Use of traditional child welfare services by adolescents include: adoption, abuse and neglect and substitute care. Adoption failure rates appear to increase with the age of the youth with the "hard to place" nine to seventeen year olds having a seventy-nine percent failure rate. Abuse and neglect in seventy-one percent of the cases involving adolescents is a continuation of maltreatment from earlier childhood abuse and neglect. Among adolescents, emotional abuse is the most frequently occurring type of abuse. This is followed by sexual abuse in forty percent of the cases of adolescent females. Substitute care is comprised of more than 50 percent of youths who are involved with child welfare. These youth have

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frequently reported health and school performance difficulties with one study reporting as high as sixty percent of these youth functioning below grade level in school. Studies have reported that from twenty to forty percent of the youth in foster care have a handicap or disability with one study identifying more than forty percent as having a chronic health problem.

In addition to the youth in the traditional child welfare services, there are increasing numbers of adolescents who have been pushed or thrown out of their homes or who have runaway from both biological and foster homes. These youth may live for short or extended periods of time on the streets of large urban areas and may intermittently make use of child welfare services including shelters, foster care and independent living programs.

In 1984 it was estimated that more than one million youth were on the street without any home to return to at night. This is far greater than the number of youth estimated to be in substitute care for the same period (from 240,000 to 400,000). The data on use of runaway shelters suggest that only approximately one third of these youth used shelters. Though it is reported that fifty-four percent of these youth

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eventually return home, this leaves a large number, nearly half a million, who do not. Many of these youth report that they left home because of abuse which they could no longer tolerate and prefer the challenges and dangers of street life to those of their biological homes.

Data describing adolescents in the child welfare system is fragmented and incomplete at best. When age breakdowns exist, the clustering of ages varies from one source to another. Thus it is often not possible to determine how many youths in any given age range have received a specific service much less what the outcome or cost of this service was. In addition upon careful examination of the available data many problems emerge including currency of the data and lack of uniform reporting across states and counties. In addition there are methodological problems with the few detailed descriptive studies which do exist. These problems presented significant barriers to describing the numbers, characteristics and issues of adolescents in the child welfare system in this paper.

There are no longitudinal, prospective studies which follow a subgroup of adolescents receiving child welfare services. Outcomes reported examine the status

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of subgroups only at the time they left a specific service. There are no data available describing what happens to any of these youth as they enter adulthood. It is often postulated that the children of these individuals may be at risk for similar behaviors and outcomes.

It is clear that there are many challenges to be met if the child welfare services for adolescents are to be improved. The changes in most state laws in the last ten to fifteen years regarding status offenses have increased the demands on child welfare services for dealing with adolescents. Though there have been a number of new and innovative programs developed, they have not been able to keep pace with the needs and numbers of these youth. In addition, the lack of data describing the scope and nature of the issues needing to be addressed has made planning for and developing new services difficult. Improved coordination across programs serving these youth as well as increased collaboration in developing options and support for services are needed. The challenges of meeting the needs of today's youth require moving beyond the categorical program approaches that have been relied upon in the past.

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CHAPTER 1

CHILD WELFARE SERVICES FOR ADOLESCENTS

OVERVIEW

This paper describes the range and types of child welfare services which are used by adolescents. It summarizes the available data regarding numbers of youth served in each service category as well as the costs of these services. Throughout the paper current issues, problems, and prospects for services are described with special attention given to gaps in services which need to be addressed and successful innovative programs. In preparing this paper the authors have drawn on government documents and papers, and journal and newspaper articles. In addition to published information, the authors have more than twenty years of experience working with children and families and community programs. These professional experiences have been invaluable, particularly in assuring inclusion of current trends, problems and prospects.

The major pieces of Federal legislation currently supporting most child welfare programs are the Child Abuse and Neglect Prevention and Treatment Act of 1974 and the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272). The Child Abuse and Neglect Prevention and Treatment Act assists states to develop programs to identify and prevent abuse and neglect and to provide ameliorative services. The Adoption Assistance and Child Welfare Act of 1980 provides incentive funds that require states to institute practices and programs to prevent unnecessary foster placement. These two acts have shaped the development and delivery of child welfare services which are provided by a broad range of public and non-profit agencies. These agencies provide child protection investigation and monitoring, adoption services, substitute care, and runaway youth shelters. Adolescents, children between 10 to 18 years old, are served by all of these agencies. The kinds of services they receive are influenced not only by their age but by trends that affect the whole child welfare system as well.

There are two major groups of adolescents who receive child welfare services. Those who have been receiving services since they were young children and those who begin receiving services for the first time when they are adolescents. This is an important distinction to keep in mind even though it can be difficult to determine when a youth receiving child welfare services first entered or came to the attention of these agencies.

Adolescents who entered the child welfare system during early childhood and who are still recipients of these services as adolescents are "long term users" of these services, and often have multiple difficulties of long standing and recurring nature. There is a strong relationship between dysfunctional families and the need for child welfare services. Therefore, children from dysfunctional families who become involved with the human service sector may remain known to child welfare agencies for much of their childhood.

The second of these two groups is adolescents who first come to the attention of child welfare services between the ages of 10 to 18. The size of this group has greatly increased over the past 10 years due to a number of changes and trends in delivery of child welfare services including changes in state laws and trends in deinstitutionalization. Juvenile codes in most states have removed status offenses such as truancy and running away from home from the jurisdiction of juvenile courts, resulting in a new population to be served by child welfare services. For instance, a large number of adolescents who would have been dealt with through the juvenile justice system are now being referred to child welfare services on the assumption they will receive help. The transfer of this population into the child welfare system has been done without sufficient additional resources being provided to help them and often without clarity as to how such service responsibility fits into an overall mission, with other priorities.

Trends in deinstitutionalization, resulting in either closure or limited use of institutional and residential settings that had served youth with mental health problems and developmental disabilities, have also contributed to an increase of adolescents in child welfare services. These youth, whose biological or legal parents are unable to provide for them may need foster care homes provided by child welfare services. In some areas this is the only residential option for this population.

Another notable group of adolescents are those in need of child welfare services but not receiving them. This group includes many runaways and street youth. These youth may have been abused but had assistance

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from child protective services. In some instances they voluntarily leave home or child welfare placements and reject further services. Of growing concern among this group are the problems of pregnant and childbearing adolescent prostitutes (Deisher, Farrow, Hope & Litchfield, 1989). Although these adolescents are being victimized by their families, pimps, and clients they are held responsible for their life situation and may be without benefit of appropriate services.

Other groups of adolescents not receiving services are children who have been sexually abused by non-family members and juvenile sex offenders. New reporting laws in many states give local police the responsibility to investigate charges of molestation by a neighbor, teacher, coach or stranger and will no longer result in the involvement of child welfare services. Juvenile sex offenders who themselves were victims of abuse are not routinely asked about prior abuse so it is not clear how many of these youth were victims of abuse themselves (Ryan, 1988). Therefore they may be prosecuted without any treatment, or if they receive treatment there is always the threat of prosecution.

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The youth described in this paper have met with challenges that society has not yet found a solution to deal with. Some of these adolescents may be viewed as victims of unresolved problems in our society. Others have benefitted from child welfare services and risen out of these circumstances.

This paper will not address Native American Adolescents as their issues are set forth in the Indian Children's Welfare Act and there are a separate set of Federal Laws that apply.

CHAPTER 2

ADOLESCENCE

The many task and role changes involved in the transition from childhood to adulthood pose a continuous series of challenges for adolescents and the adults who must deal with them (Olsen & Holmes, 1986; Edlin & Mitchell, 1983). All adolescents face common issues in such areas as sexuality, educational and vocational choices, drugs and alcohol, relationships with family, and financial independence. Adolescents needing child welfare services have similar problems to adolescents in general but their problems may be greatly exacerbated due to the circumstances that brought them to the attention of social service agencies.

Edlin & Mitchell (1983) describe three developmental stages of adolescence: early, middle, and late. The early stage is roughly between 12 and 14 years of age when the adolescent is primarily involved in adapting to the physical changes of puberty. During middle adolescence, 15 through 17 years of age, the adolescent is engaged in developing independence from the family and forming relationships with peer groups.

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Late adolescence covers roughly from 18 years of age to the early 20s and the adolescent is oriented to the future. According to Algate, Stein, and Carey (1989) the period of adolescence in many families marks a shift in the relationship between parents and young people, with an increase in negotiated decision-making and independence.

The development of an adult identity, the growth of autonomy, and the acquisition of new roles by the adolescent are all processes that may lead to conflict with adults (Blos, 1972; Erickson 1968). This conflict is intensified by pre-existing stresses in the family, new stresses, and changes associated with the family's life cycle (Garbarino & Gilliam, 1980). Challenges presented during a period of confusion, anxiety, and ambivalence in the adolescent as he/she is establishing identity can also heighten family conflict. Adolescents who react to these problems and conflicts often behave in ways that are labeled by adults as disruptive and uncontrollable (Olsen & Holmes, 1986).

CHAPTER 3

BEHAVIORS AND CONDITIONS WHICH BRING YOUTH IN CONTACT WITH CHILD WELFARE SERVICES

The reasons youth are referred to child welfare services vary from state to state and county to county depending on state laws and agency practices. The issues that bring adolescents into contact with the child welfare system are likely to result from a combination of the normal changes occurring during adolescent development and of extraordinary family and environmental stresses that impinge on the teenager (Lippnow, 1985).

Hoghughi (1989) lists the following conditions which may bring adolescents to the attention of child welfare services: 1) being physically abused or neglected; 2) being mentally handicapped and not receiving adequate care; 3) having a seriously unsatisfactory home where the normal requirements of care and control are not met; 4) committing such delinquent acts as to make continued stay at home undesirable; 5) being promiscuous or mentally disturbed; and 6) not receiving adequate care at home. There are also adolescents who seek child welfare

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services on their own by going to shelters or walk in clinics.

Lisbeth Schorr (1988) in her book "Within Our Reach" refers to the "children of the shadows". These are children who have behaviors and problems which are cause for concern, but which are not so extreme as to fall into the realm of juvenile justice or mental health services. These are often the children and youth who are in child welfare services. Ignoring the needs of these adolescents may result in their becoming clients of the juvenile justice or mental health systems.

Additional information regarding the specific behaviors and conditions which bring adolescents into contact with the child welfare system will be included with the description of child welfare services.

CHAPTER 4

UTILIZATION OF CHILD WELFARE SYSTEM

Child welfare services described in this paper include: Child Protective Services, Adoption Services, Substitute Care (includes foster care and emergency shelters), and Centers and Shelters for Runaway Youth.

A separate section will be devoted to each of these four service areas and will include: a discussion of the problem or condition that bring the youth into contact with the agency; estimates on the number of youth served by each agency; methods by which this utilization information is collected and reported; breakdowns by age, sex and ethnic group when available; and information regarding outcomes for youth served.

It is difficult to obtain accurate national data describing the utilization of the child welfare system by adolescents ages 10 to 18 years. There is no uniform way in which state and county child welfare agencies keep data regarding the numbers and characteristics of the children they serve.

The federal government dismantled its child welfare statistical activities in the 1970s and relied on a voluntary data system for child welfare in the 1980s. Regulations for reporting are currently being reviewed with the hope of more detailed information being available by 1991 or 1992.

Another problem in collecting data is the inconsistency in the terms used to describe child and family social services. Kamerman and Kahn (1989) in their review of social services for children, youth and families found "child welfare" included child protective services in some locales, while in others it was a distinct and separate service category. They also discovered a "child awaiting adoption" may be one for whom the home study has actually been completed, or one whose parents' rights have been terminated but no adoption process even begun. The definition of a "case" often varies and at times a child is counted as a case while at other times the entire family may be counted as a case. Allegations of abuse and/or neglect may be treated as a separate case or may be treated as multiple cases.

In addition, definitions of programs or lines of responsibility between programs vary from area to area. For example, states have different definitions of which youth are served by child welfare services, and which become the responsibility of the juvenile justice or mental health systems. These distinctions may vary even within a state, especially in those states which have county based child welfare systems. Since some child welfare services are provided by private non-profit agencies, there is great variability with regard to how data regarding the services they provide are reported.

CHAPTER 5

CHILD PROTECTIVE SERVICES

DEFINITIONS OF CHILD ABUSE AND NEGLECT

Since the mid-1970s, there has been a substantiated increase of the awareness of and programs for adolescents who have been abused and/or neglected (Berdie & Medina, 1984). "Child abuse" and "child neglect" are terms that are applied to a diverse set of phenomena. Child abuse is a complicated and confusing subject, particularly in the area of defining which behaviors, both legally and in professional judgment, constitute abuse or violence. Attempting to define these terms has become one of the most controversial issues in child abuse and neglect work because the definition of these terms can determine what constitute reportable circumstances. They establish when society, child protective services, and possibly the courts, can intervene in family life.

The problems which most often beset the definitions of adolescent abuse and neglect are vagueness and narrow interpretation (Berdie & Medina (1984). It is difficult to draft legislation which is specific enough to prevent improper application, and yet broad enough to cover situations of harm to a child necessitating societal intervention.

In attempting to define adolescent abuse and neglect it is most important to be aware of characteristics of the developmental stage of adolescence since these can be a precipitating or contributing factor to the maltreatment. Society tends to accept overly strict, even abusive, disciplining of an adolescent much more readily than a younger child.

Adolescents who are physically maltreated are often not defined as "abused" because the injuries are not considered sufficiently severe. The older the victim, the greater the chance his injury will be seen as both minor and deserved, and thus not be "abuse". When teenagers report mistreatment, they may encounter suspicion instead of sympathy. The person being told may not even believe it is possible to abuse an adolescent. Few people would assume that infants cause their own abuse; but people do tend to ask teenagers what they did to deserve whatever ill treatment they received.

Adolescents who are maltreated may not come to the attention of the social service system as "abused" or "neglected." Many cases of adolescent abuse and neglect are never recognized as they are masked by other presenting problems or behaviors resulting from maltreatment. Frequently adolescents labeled as delinquents, status offenders, prostitutes, drug abusers, runaways, suicidal, pregnant teenagers, are actually identified abused and neglected youth. As a result, a significant number of the seriously abused and neglected adolescents and their families have no contact with the child protective system (Fisher et al., 1980).

Abused adolescents are more likely to be served by the juvenile justice system or the mental health system than by the child protective system (Fisher et al., 1980). These authors found abused or neglected adolescents, unlike younger children, often come to public attention because of their disruptive behavior, rather than as a result of what has happened to them. They run away, steal, fail or skip school, fight, set fires, or behave in other ways which put them in contact with the juvenile justice system or mental health system. These disruptive behaviors may be the adolescent's only method for getting attention and help (Fisher et al., 1980).

Many cases of adolescent abuse and neglect are recognized as such by service providers, but are never reported to child protective services (Fisher et al., 1980). Many youths' service providers have concerns about reporting adolescent abuse and neglect to child protective services or to the police. Many youth workers believe they should report such cases only as a last resort. Fisher et al., (1980) list a variety of reasons for this reluctance to report:

1. Professionals often believe that CPS and/or police intervention would be minimal, and that the case would not be accepted for services.
2. Professionals believe that reporting such cases would be a breach of a confidential and trusting relationship with the client and a detriment to the agency's reputation in the client community.
3. Professionals often believe that police and/or CPS intervention would worsen the family conflict rather than improve family functioning.
4. Professionals often choose not to report such cases based upon their own assessment

of the case as one not involving substantial risk of harm to the client.

5. Professionals' assumptions about the juvenile court's approach to adolescent abuse and neglect also discourage reporting. Potential reporters often choose not to report such cases because they believe insufficient evidence exists to prove such allegations in court.

PATTERNS OF MALTREATMENT

The patterns of maltreatment according to Anderson (1984) are commonly characterized as: 1) maltreatment which has continued from childhood through adolescence; 2) maltreatment which began in childhood, ceased but begins again in adolescence; and 3) maltreatment which begins in adolescence.

Berdie & Wexler (1984) analyzed data on 207 adolescents, ages 12 through 17 years, from three adolescent maltreatment projects. They found in 71% of the cases adolescent maltreatment is most often an extension of child maltreatment. In 23% of the cases, maltreatment began during adolescence, and the remaining 6% of the cases were of the interrupted

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pattern type. Of the youth for whom type of maltreatment could be determined, 68% experienced emotional maltreatment, 54% physical abuse, 35% experienced neglect, and 24% experienced sexual abuse.

Garbarino and Garbarino (1987) suggest that the causes and effects of each pattern of abuse may be quite different. They found adolescents with a history of long term abuse to be heavily concentrated among low-income groups. Victims of long-term abuse tend to grow up in families characterized by unmanageable life stresses and inadequate coping resources. While abuse and neglect can and do occur in all sectors of our society, the conditions of day-to-day life among socio-economically deprived families conspire to produce more outbreaks of child maltreatment. The parents of this group are somewhat more likely than others to have been victims of abuse as children or to have a history of spouse abuse.

Abuse that begins in adolescence presents a quite different picture, and these cases are more evenly spread across the population. Garbarino & Garbarino (1987) found that poverty was less likely to be a major factor than it was for adolescents who had histories of abuse since childhood, and that parents were more likely to be married and relatively stable. They suggest abuse beginning in adolescence may have been triggered by the tension between parental needs for control and the adolescents striving for independence from parental control.

INCIDENCE OF ADOLESCENCE ABUSE AND NEGLECT

The Study of National Incidence and Prevalence of Child Abuse and Neglect was commissioned by the National Center on Child Abuse and Neglect (NCCAN), Administration for Children, Youth and Families in the Office Human Development Services, U.S. Department of Health and Human Services (U.S. DHHS, "Study Findings," 1986). It was conducted in response to a specific Congressional mandate in the Child Abuse Amendments of 1984 (P.L. 98-457). This study is also referred to as the second National Incidence Study (NIS-2) and its purpose was to assess the current national incidence of child abuse and neglect, and to determine how the severity, frequency, and character of child maltreatment had changed since the NIS-1, which was completed in 1980.

Two sets of standardized definitional criteria were used to assess the 1986 data. One set corresponded identically to the definitions used in the NIS-1 and the second set of definitional standards were broader and more inclusive. The second set provided a supplementary estimate which reflected the incidence of children who were endangered by maltreatment. The first set of data can be compared with the 1980 data whereas the second set of data cannot be compared with the 1980 data because of the more inclusive definitions.

Data were collected concerning cases of child maltreatment which were recognized and reported to the study by "community professionals" in a national probability sample of 29 counties throughout the United States. The "community professionals" who participated in the study included the local Child Protective Services staff as well as key respondents in a variety of other non-CPS agencies (such as schools, hospitals, police departments, juvenile probation authorities, etc.). All cases reported to the research study were assessed for their conformity to two sets of standardized definitional criteria, and only those cases which fit these criteria were used as the basis of national estimates. This report provides estimates of the numbers of children, ages 0 to 17, who experienced countable maltreatment according to original NIS-1 definitions of maltreatment and according to revised definitions. Although these reports include data for all children ages 0 to 17, this discussion will focus on data for children ages 10 and above.

In 1986, an estimated 16.3 children per 1,000 or a total of more than one million children nationwide experienced abuse or neglect (meeting the original standardized study definitions of maltreatment). Under the revised expanded definitions, an estimated 25.2 children per 1,000 or a total of more than one and one-half million children nationwide experienced abuse or neglect in 1986 (U.S. DHHS, "Study Findings," 1986).

The 1980 vs 1986 comparisons indicated that cases countable under the original standards increased significantly in the interim since 1980, from about 9.8 to about 16.3 children per 1,000 (a 66% increase), representing an increase from 625,100 to 1,025,900 children (a 64% increase). The authors concluded the differences reported between the two studies as statistically significant. Furthermore they demonstrate real differences in incidence rather than simply an increase in the professional's ability to recognize countable cases.

Age Differences in Abuse and Neglect

Within the subcategories of abuse, there were age-related differences for physical, emotional, and sexual abuse. The incidence of physical abuse and sexual abuse generally increased with increasing age. The incidence of emotional abuse increased with age until age 12-14 and then it decreased for ages 15-17. This information is illustrated in table 5-1.

Educational neglect was the largest neglect category and there appears to be a dramatic increase in incidents between the 9-11 age brackets and the 15-17 year age brackets. See table 5-2 for this information.

There were significant age differences for two of the severity levels: fatalities and moderate injuries/impairments. The risk for fatalities as a result of maltreatment occurred largely in the lower age brackets whereas the incidence rates for moderate injuries/impairments generally increased with increasing age.

The 1980-1986 differences related to child's age indicated that there had been significant increases in

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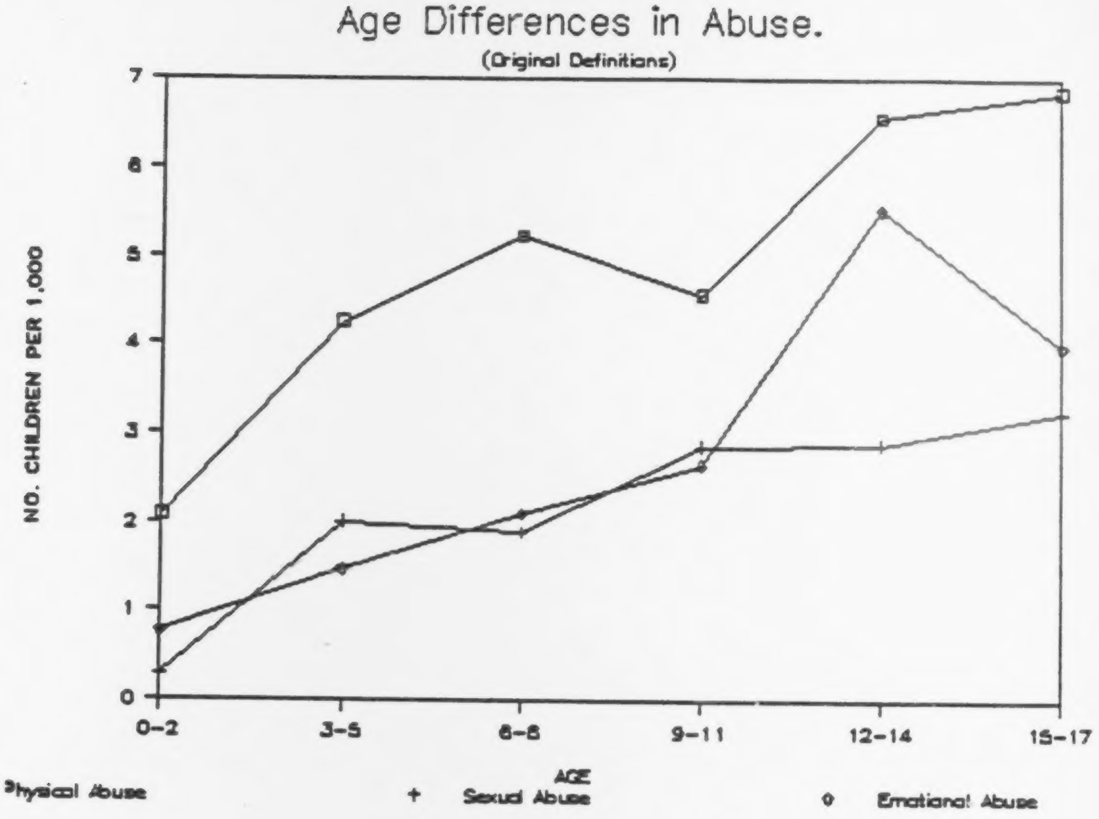
Table 5-1



Source: U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect, Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services. Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988. (Washington, DC: 1989).

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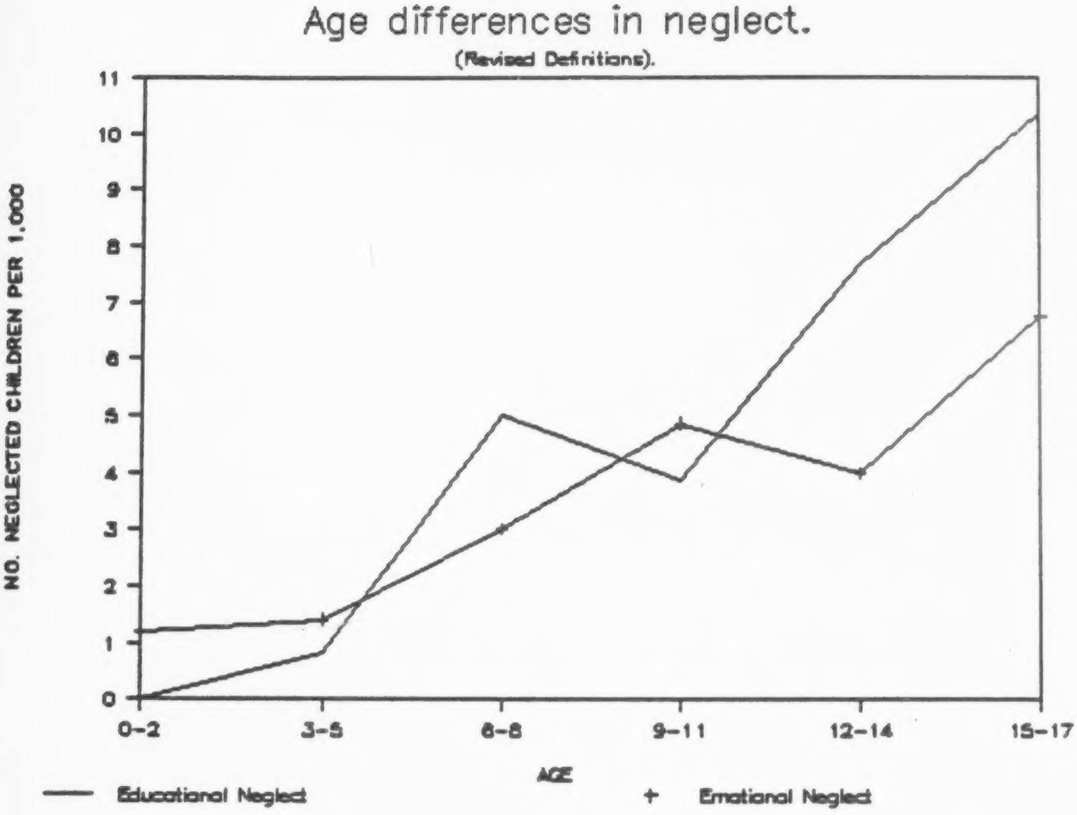
Table 5-2



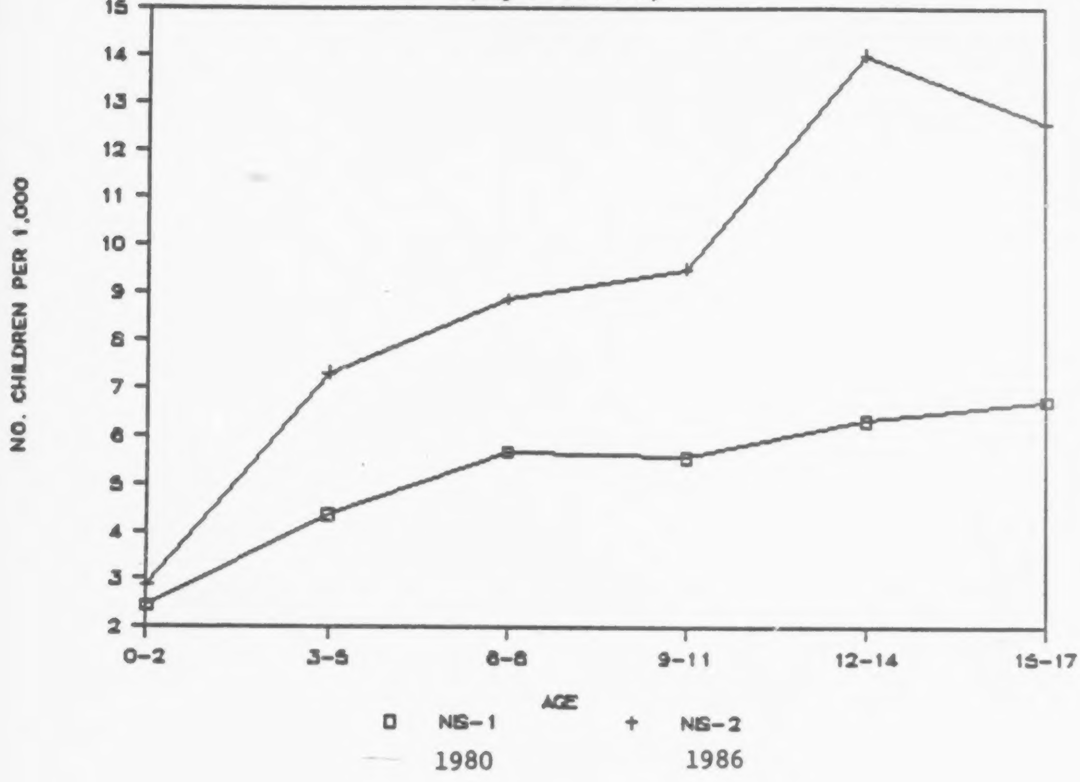
Source: U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect, Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services. Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988. (Washington, DC: 1989).

abuse, but not in neglect, and that within the subcategories of abuse, these increases had occurred in both physical and sexual abuse (but not in emotional abuse). At the same time, moderate injuries/impairments had increased significantly above their 1980 levels. Table 5-3 presents the changes in all abuse by age groups between 1980 and 1986.

Sex Differences in Abuse and Neglect

Analyses indicated that, in general, the pattern and distribution of child maltreatment was very similar for both males and females. However, under both the original definitions and the revised standards, females experienced more abuse overall than did males. This reflected primarily their greater likelihood of susceptibility to being sexually abused. Their greater vulnerability to sexual abuse also made them more likely to experience "probable" injury/impairment in comparison to males. Sex of child did not appear to relate to any of the changes observed between 1980 and 1986 study findings.

Table 5-3



Changes in All Abuse by Age Group.

(Original Definitions)

Source: U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect, Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services. Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988. (Washington, DC: 1989).

Race/Ethnicity Differences in Abuse and Neglect

There were no significant relationships between the incidence of maltreatment and a child's race/ethnicity.

Family Income Differences in Abuse and Neglect

Family Income was divided into those earning $15,000 or more and those earning less than $15,000 in 1986 and relationships between this factor and the type and severity of child maltreatment were identified. Family income was found to have a profound effect on the incidence of abuse and neglect. There were significant income-related differences on all measures except fatalities, and there the differences were marginal. Low income was a significant risk factor for child maltreatment. Under the original study definitions, children from families whose 1986 income was less than $15,000 experienced significantly more maltreatment than those from families earning $15,000 or more. Family income failed to affect any of the overall 1980-1986 differences.

PROBLEMS WITH REPORTING INFORMATION

Incidence studies of child maltreatment must rely on systematically collected official statistics. These statistics may not be provided by all states or by all areas within participating states. Definitions of child abuse and neglect are not uniform from state to state. In addition, reported cases constitute only a fraction of actual abuse and neglect incidents. Other research efforts may fail to accurately measure incidence because of ambiguous definitions of child maltreatment or because local or regional estimates are improperly projected on a national basis. Because of these problems, figures of the incidence of child abuse often seem contradictory and are quite varied.

DISPOSITION

Disposition of children and adolescents who have been abused is determined by state laws and agency practices. Since the 1980 Child Welfare Act there has been an emphasis on returning to and remaining in the biological parents' home.

CHAPTER 6

ADOPTION

During the last twenty years there have been many changes in adoption programs. In the past, the major task of adoption workers was the problem of selecting families for the few babies available from an oversupply of childless couples who wanted to adopt them. Presently, the goal of adoption is to assure that children who are unable to live with their biological families are provided with non-institutional placements.

The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) supports the goal of a permanent, safe, family-like living situation for every child. This law emphasizes that each child should be placed in the least restrictive or the most family-like setting available, in close proximity to the birth parents' home, and consistent with the best interests and special needs of the child. As a result of P.L. 96-272 and related changes in the child welfare system, large numbers of older and special-needs children are entering adoptive placements.

INCIDENCE REPORTS FOR ADOPTION

The Child Welfare Statistical Fact Book, 1985: Adoption (U.S. DHHS, "Adoption," 1988), reports the fourth annual collection of State aggregate data by the Voluntary Cooperative Information System (VCIS). This book includes data on the national estimates for children waiting to be adopted, children adopted, and children in non-finalized adoptive homes during the 1985 reporting period for children ages 0 to 20. The data presented below have been summarized from the above referenced book.

The national estimate for children, ages 0 to 20, adopted during the 1985 reporting period was 16,228. Of this estimate, 76% were ages 0 to 10 and 24% were ages 11 to 20. The estimate for children, ages 0 to 20, living in non-finalized adoption homes was 15,349 of which 81% were ages 0 to 10 and 19% were ages 11 to 20. The estimate for children waiting to be adopted was 16,197, and of this estimate, 59% were ages 0 to 10 and 41% were ages 11 to 20. Table 6-1 shows age percentage according to adoption status. The percentage of children ages 0 to 10 adopted and living in non-finalized adoption homes is considerably higher than that of children ages 11 to 20. There are more

Table 6-1

Age Percentages per Adoption Status

	Adopted (N = 16,228)	Non-Finalized (N = 15,349)	Waiting (N = 16,197)
Ages 0-10	76%	81%	59%
Ages 11-20	24%	19%	40%
Ages 11-15	19%	16%	28%
Ages 16-17	4%	3%	7%
Ages 18-20	1%	1%	5%

Source: Adapted from U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Planning and Management, Child Welfare Statistical Fact Book - 1985: Substitute Care (Washington, DC: May 1988).

children in the 0 to 10 age group who have been adopted or placed in non-finalized adoption homes than are waiting for adoption, whereas, the reverse is true for the 11 to 20 age group. More 11 to 20 year olds are waiting for adoption homes than have been adopted or have been placed in non-finalized adoption homes.

Table 6-2 presents the racial classification of children, ages 0-20, seeking adoption during the reporting period of 1985. Black children represent 25% of the children adopted, 25% of the children in non-finalized homes and 38% of the children waiting to be adopted. White children represent 58% of the children waiting to be adopted, 55% of the children in non-finalized adoptive homes, and 54% of the children waiting to be adopted. Other minority children represent 17% of the children adopted, 20% of children in non-finalized adoptive homes and 8% of the children waiting to be adopted.

ADOPTION DISRUPTIONS

As the number of older children and children with special needs being adopted have increased, the number of disrupted placements has also increased. The additional demands placed on all of the participants in

Table 6-2

Adoption Status by Racial Groups

	Children Adopted During this Period	Children Free for Adoption	Children In Non-Finalized Adoptive Homes
Classified by Race			
White	9,462	8,412	8,312
Hispanic		1,108	1,356
Black	3,731	6,139	3,887
Other	2,894	426	1,696
Unknown	141	112	98
Total Children	16,228	16,197	15,349

Source: Adapted from U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Planning and Management, Child Welfare Statistical Fact Book - 1985: Substitute Care (Washington, DC: May 1988).

the adoptive situation are great, and no matter how careful the preparation of both child and family, the placement may not succeed (Barth et al., 1986). Disruptive adoptions reportedly occur in families with less flexible family roles and rules (Sack & Dale, 1982), in families with insufficient training or information about the child (Pardeck, 1983), and in families with too many stressors and too few resources (Zwimpfer, 1983). Children's characteristics associated with adoption instability include behavioral and emotional problems, and previous adoptive placements (Kadushin & Siedl, 1974; Donley, 1983).

Tremitiere (1984) reviewed approximately 2,500 adoptions from 1979 to 1983 and found that 6- to 12-year old children had a disruption rate of 9.7% compared to a rate of 13.5% for 12- to 18-year-old-children. Boyne, Denby, Kettenring & Wheeler (1984) found disruption rates of 22% for the age group of 0 - 8 year olds and 72% for the age group of 9 - 17 year olds among 219 hard-to-place children.

POSTADOPTION SERVICES

In the adoption of older and special needs children adoptive parents may well need help after placement, since the adoption of an older or special needs child may require skills that are themselves special and out of the average person's experience. This recognition that many children being placed will need continued professional help has changed the belief that adoptive families need to be free of the agency as soon as possible so they can function as independently as any family (Cole, 1985).

Families who adopt an older child or a child with special needs may need help in two particular areas. First, they may need help in understanding and helping their child. Second they may need help with the impact of the child on their lives and on the organization and functioning of their family.

OUTCOMES

The evidence on the outcomes of older-children adoptions is sparse. Barth & Berry (1987) report the majority of investigation on adoption outcomes are of infant adoptions although there are many older-child adoptions. Reid et al., (1987) report that little research has been published on the quality of the adoptive experience for a cross section of families who have adopted older and "difficult children".

Very little is known about outcomes of adoptive placements of older children who have experienced serious neglect and physical abuse in their biological families, and multiple placements in foster homes, psychiatric hospitals, juvenile detention facilities, and residential treatment centers (Reid, Kagan, Kaminsky, et al., 1987).

CHAPTER 7

SUBSTITUTE CARE

When biological families or legal guardians are unable or unwilling to provide safe and adequate care for their dependents, child welfare services are often asked to assume the role of arranging for and monitoring the shelter, nurturance and sustenance that is needed by these children. Out of home or substitute care may be provided through a range of programs which include: receiving home or shelter, foster care, group home, nursing home, or institution. Foster care is the most commonly used of these settings, accounting for care provided to more than 250,000 children and youth in 1985.

According to Aldgate, Maluccio & Reeves (1989), adolescents in foster care constitute several different groups with differing needs and characteristics. First, there are those who were placed at an early age and have had a stable history in foster care; second, there are those who were placed at an early age and have been moving from one placement to another because they are described as "difficult to deal with;" and third, there are those who were placed for the first time as teenagers, usually because of their behavioral or relationship problems. The number in this third group has been growing because of court attempts to divert young people from the correctional or criminal justice system and those changes in state laws described in the introduction. Although the exact number of status offenders receiving child welfare services is not known, the Children's Defense Fund FY 1988 reports the number of status offenders in secure facilities declined from 200,000 in 1979 to 25,000 in 1984 (Children's Defense Fund, 1987). Most of the 150,000 youth who were no longer served in "secure facilities" would have become the responsibility of child welfare services if they were to receive services.

Alfred Kadushin (1980) attributed the increase in the proportion of adolescents in foster care to the following factors: 1) the large number of children who began a foster-care career at an early age, 2) decreased external family supports and social control influences, 3) increased willingness of parents to turn "difficult" adolescents over to public social service agencies and 4) diversion of status offenders into the child welfare system.

PROBLEMS LEADING TO PLACEMENT IN FOSTER CARE

Studies cite the reasons for placement in different ways and order of importance: a configuration of factors common in many placement situations includes poverty and/or lack of resources; breakdown of family system functioning; and insufficient informal support networks to tide the family over through a crisis situation or to provide respite in a situation of chronic difficulty (McFadden, 1985).

The need for child protective services was a primary reason for 61% of the children requiring substitute care (U.S. DHHS, "Substitute Care," 1988). The primary reasons children are removed from their home and placed in substitute care are outlined in table 5. These data indicate children are most frequently removed from their homes due to parent reasons (77%) rather than child behavior problems (6%) or handicapping conditions (2%).

Adolescents come into placement under widely differing circumstances, for a multitude of reasons, and through processes which may vary from agency to agency, county to county, and state to state. Data available do not distinguish reasons for placement by age and many adolescents entered the system before they were in this age group. In a study of children in foster care, Shapiro (1976) lists the following reasons for placement for all children; 1) unwillingness or inability of the parent to continue care, 2) neglect or abuse of the child, 3) mental illness of the parent, 4) unwillingness or inability to assume care (in the case of a newborn), 5) child's behavioral or personality problems, 6) illness within the family, 7) incarceration of the parent, 8) conflict within the family, 9) drug addiction of the parents, and 10) alcohol-related problems.

United Way, Inc. (1987) reports the reasons for foster placement of the 14,806 children in Los Angeles County, for all age groups, in June 1985 as follows: neglect 36%, physical abuse 24%, caretaker incapacity 16%, sexual abuse 13%, and other 11%.

SUBSTITUTE CARE INCIDENCE REPORTS

The Child Welfare Statistical Fact Book, 1985: Substitute Care (U.S. DHHS, "Substitute Care," 1988), reports the fourth annual collection of State aggregate data by the Voluntary Cooperative Information System

(VCIS). This book includes data on children in substitute care at the start of the reporting period; children entering care during the reporting period; children leaving care during the reporting period; and children in substitute care at the end of the reporting period. National estimates on the substitute care population are based on the total number of children in foster care on the last day of the 1985 VCIS reporting period.

There were 265,744 children, ages 0 to 20, in care at the start of the 1985 reporting period. A breakdown of ages for these children is not available. An estimated 187,066 children entered substitute care during the 1985 reporting period. Fifty-three percent of this estimate were children in the 0-10 age bracket and 47% of this estimate were children in the 11-20 age bracket. The number of children estimated leaving care during the reporting period was 176,543. Of this estimate, 46% were children ages 0-10 and 55% were children ages 11-20. At the end of the reporting period, an estimated 276,266 children ages 0 to 20 remained in substitute care. Of these, 46% ranged from 0 to 10 years of age, while 54% ranged from 11 to 20 years of age.

For ages 0 to 10 more than 50% entered substitute care and less than 50% left substitute care or remained in substitute care at the end of the 1985 reporting period. The pattern changes for the 11 to 20 age group as less than 50% entered substitute care and more than 50% either left substitute care or remained in substitute care at the end of the reporting period. table 7-1 illustrates these percentages. The outcomes of children leaving substitute care during this period for all children are as follows: 66% were returned to their home, 9% were adopted, 8% were emancipated, 4% ran away, 2% were discharged to another agency, and 10% were either another outcome or unknown outcome.

Of the estimated number of children, ages 0 to 20, who entered substitute care in 1985, 59% were White children, 24% were Black children, and 17% Hispanic, others and unknown. At the end of the reporting period 54% of the remaining children were White, 33% were Black, and 13% were of Hispanic, other or unknown ethnicity. The proportion of Blacks entering and leaving substitute care dropped slightly between 1983 and 1985 while that of other minorities has risen. Longer term data show a stable Black share with rising share for other minorities. Data displaying trends in

Table 7-1

Age Percentages According to Substitute Care Status

	Entering Substitute Care (N = 187,066)	Leaving Substitute Care (N = 176,543)	Remaining in Substitute Care (N = 276,266)
Ages 0-10	53%	46%	46%
Ages 11-20	47%	55%	54%
Ages 11-15	32%	27%	30%
Ages 16-17	14%	17%	16%
Ages 18-20	2%	11%	7%

Source: Adapted from U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Planning and Management, Child Welfare Statistical Fact Book - 1985: Substitute Care (Washington, DC: May 1988).

the proportions of minority children served by substitute care is shown is table 7-2.

These data which are national in scope have many problems inherent in their reporting. The characteristics of adolescents in foster care are more clearly understood from several studies which have been carried out in a single state or county. In a 1985 study conducted by Los Angeles County United Way there were 14,000 children in out of home care (United Way, Inc. 1987). Fifty-two percent of these children were between the ages of 9 and 18, with 20% being between 9 and 12 and 32% being ages 13 and above. There were slightly higher numbers of females than males, and more than 1 and 1/2 times greater number of blacks than whites or Hispanics. More than 50% of these youth were noted to have health and/or learning problems.

In 1986 in the state of Ohio there were reported to be 16,229 children in out-of-home care (Urban Systems Research and Engineering, Inc. 1987). Over 56 per cent of these children were between the ages of 13 and 18 years of age. In this study it was estimated that two-thirds of the children in out of home care had problems in at least one of the following three areas:

Table 7-2

Substitute Care Population Flow According to Racial Classification

	Children Entering	Children Leaving	Children in Care End of Period
White	107,659	104,189	150,170
Hispanic	20,032	16,335	16,252
Black	43,577	42,170	91,045
Asian/Pacific Island	2,603	2,271	3,156
American Indian/ Alaskan	5,000	4,786	4,845
All Others	3,244	2,782	7,244
Unknown	4,952	4,010	3,553
Total	187,066	176,543	276,266

Source: Adapted from U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Planning and Management, Child Welfare Statistical Fact Book - 1985: Substitute Care (Washington, DC: May 1988).

1) Mental retardation and developmental disability - 20%; 2) Mental health problems - 30%; and 3) Behavior and adjustment problems - 50%. Ten percent were reported to have problems in all three of the above areas.

A 1985 study in Connecticut of 779 youth in long term foster family care reported that 39 percent of these young people were over the age of 16 (Kluger, Maluccio, & Fein, 1989). Kluger, Fein, and Maluccio (1986) report on a study which focused on children and young people who were in long-term foster family care. Since this study used the entire population of foster care youth in the state, sampling errors were eliminated and a large number of subjects for sub-group comparisons was provided. Thirty-nine percent of the study population were 16 to 20 year olds and 61% were 2 to 15 year olds. There were similar numbers of males and females in each age group, and both groups had approximately the same number of placements during their time in care. Compared to the younger children, however, the 16 to 20 year olds were more likely to be white and to have entered care because of economic/environmental and family interaction problems rather than defined abuse or neglect. These data are presented in table 7-3.

Hill, Lakin, Novak and White (1987) using 1985 data, found the national average prevalence of handicaps among foster children was 20.5% with a range of from 3% in Florida to 58% in Nevada. In 11 out of 35 states it was indicated that 33% or more of the children and youth in foster care were handicapped, while in ten states it was reported that less than 15% of these children were handicapped. These data are presented in table 7-4. A study of 6,279 children in out-of-home care in Louisiana in 1982-1983 found 17% of the total number of children were found to be disabled (Louisiana State Planning Council on Developmental Disabilities, 1984). These studies also described significant information about the health and school performance status of these children.

HEALTH AND EDUCATION NEEDS OF ADOLESCENTS IN FOSTER CARE

Health care is inconsistently provided and monitored for adolescents who are in child welfare services. In general there is no clear mandate or resources dedicated to address the health care of this

Table 7-3

CHARACTERISTICS OF CHILDREN AND YOUTH IN LONG-TERM FOSTER FAMILY CARE

Characteristics	*% of 16 to 20-year-olds (n=307)*	*% of 2 to 15-year-olds (n=472)*
Sex		
Male	47	54
Female	53	46
	100	100
Race/ethnicity[a]		
White	59	47
Black	37	41
Hispanic	4	12
	100	100
Time in foster care[a]		
<3 years	11	31
4–5 years	17	27
6–10 years	19	23
≥10 years	53	19
	100	100
Time with current foster family[a]		
<2 years	34	35
2–5 years	26	39
>5 years	40	26
	100	100
Age at entry[a]	7.5 years old	4.1 years old
Number of placements		
1 or 2	66	70
>2	34	30
	100	100
Reason for entry into care[a]		
Neglect	59	64
Abuse	8	13
Other (e.g., economic/environmental, family interaction problems)	33	22
	100	99[b]

[a] Statistically significant difference at the .01 level.

[b] Percentage does not total 100 due to rounding.

Source: Kluger, M., Maluccio, A. & Fein, E. (1989). Preparation of adolescents in life after foster care. In J. Aldgate, A. Maluccio & C. Reeves (eds) Adolescents in Foster Families. Lyceum Books, Inc. Chicago. Page 79.

Table 7-4

Handicapped Children in Foster Care by Type of Placement: 12/31/85

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	316	5	92	2		2	65	61	543
Alaska									
Arizona	928	117	47						1,092
Arkansas								453	453
California	3,356	1,260	625					124	5,365
Colorado	385	95	135	10		18			643
Connecticut	236	29	391	19	133	26		78	912
Delaware									
Dist. Columbia									
Florida	17	4	85	6		1	26	110	249
Georgia	998								998
Hawaii	75	4	15	2			23		119
Idaho								130	130
Illinois	460	49	329		20	72	662	31	1,623
Indiana	1,118	150	417	54	19	4	242	145	2,149
Iowa	347		738	30	8	1		37	1,161
Kansas	483	307	218	52		6	284	112	1,462
Kentucky	719								719
Louisiana	561	134					152	33	880
Maine									
Maryland	956		505	89	8	9	181	2	1,750
Massachusetts									
Michigan	836	7	543	26	43	88	364	24	1,931
Minnesota								2,058	2,058
Mississippi								288	288
Missouri	1,502	122	597	7	9	35		204	2,476
Montana								249	249
Nebraska	837	185	201	33	3	25	401	75	1,760
Nevada								748	748
New Hampshire									
New Jersey									
New Mexico								162	162
New York	3,840	1,125	1,991					3	6,959
North Carolina	169	8	60	2	11	4	42	14	310
North Dakota									
Ohio	2,094		1,166				1,480	321	5,061
Oklahoma	267	2	116		19	1		1	406
Oregon	736	16	180	39	89	2			1,062
Pennsylvania									
Rhode Island								549	549
South Carolina									
South Dakota									
Tennessee	920								920
Texas									
Utah	177	24	31		1	8	28	74	343
Vermont	51							198	249
Virginia	715		293	5		28	42	32	1,115
Washington								474	474
West Virginia									
Wisconsin	258	20	88						366
Wyoming									
Reported	23,357	3,663	8,863	376	363	330	3,992	6,790	47,734

Note. NC = not classified
For estimated U.S. total, see Table 6.

Source: Hill, B.K., Lakin, K.C., Novak, A.R., & White, C.C. (1987). Foster care for children and adults with handicaps: Child Welfare and adult social services (Report No. 23). Minneapolis Department of Educational Psychology. Table 3.

population. Additionally, very little information exists on the sexual activity rates or prevalence of pregnancy and childbearing among teens in foster care.

Studies have shown foster children to be in poorer health and more likely to suffer from chronic medical conditions. White & Benedict (1986) report on a study conducted by the Johns Hopkins School of Hygiene and Public Health on the health status and health services utilization of 417 foster care children in Baltimore, Maryland. They found that nearly half of the 10 to 14 year olds and 35 percent of the total group of children just entering care were rated low in health status. Those in care at least 18 months also reported numerous health problems. Caseworkers reported not having information on health history and current health status of children who were in their care.

Halfon & Klee (1986) reported on a study on the health status of foster children in which social workers, foster parents, and health care providers responding generally, reported that health status at placement ranged from fair to poor. Two-thirds of the conditions identified were characterized as mild acute or mild chronic and were perceived as relatively easy to treat. They also reported that fragmentation and lack of coordination in the delivery of health services to foster children made even basic services for mild, treatable conditions hard to get.

Studies of health of children in foster care in Los Angeles have reported that 40 to 45% of the children had chronic health problems (United Way, Inc. 1987) and more than 50% of the children had decayed teeth (Kavaler, Swire, 1983; Hochstadt, Jaudes, 1984; Schor, 1982).

Many children in foster care are deprived of the opportunity for adequate educational achievement by a childhood that is interrupted by trauma and transition (Barth, 1986). Little information is available regarding the educational needs or problems of children that result from abuse, neglect and multiple placements. Furthermore, there is often no communication between the educational and child welfare systems.

When the general level of educational attainment of children in out-of-home placement in Ohio was examined, it was found that three out of five school age children in this group were performing below grade level in reading and math (Urban Systems Research and Engineering, Inc. 1987; United Way, Inc. 1987).

OUTCOMES

Data on long term outcomes of children in foster care are not readily available. At this time there are no long term studies which examine what happens to youth who have left foster care.

The research generally concludes that older children are more likely to experience unstable care (Pardeck, 1980, 1983, 1984). Even though there is a common feeling among professional child welfare workers that the minority child is a likely candidate for unstable foster care, there is very strong evidence that the white foster child is more likely than the minority child to experience multiple re-placements (Olsen, 1982; Pardeck, 1983). Studies also report that male and female foster children experience similar rates of re-placement (Pardeck, 1983).

Pardeck (1985) studied re-placement of children in foster care and developed a rudimentary profile of the child who is likely to experience unstable foster care. Those characteristics contributing to unstable foster care are age of child, behavioral or emotional problems, parents who have a tendency to be alcoholic, high caseworker turnover, and foster parents who lack training to work with children who have behavioral or emotional problems.

CHAPTER 8

RUNAWAY YOUTH CENTERS

The Runaway Youth Act, Title III of the Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93-415) was enacted in response to concerns raised by the increasing incidence of youth who were leaving home without parental permission. The Juvenile Justice Amendments of 1977 (P.L. 95-115) provided assistance to states to develop programs designed to serve youth while away from home and living on the streets. The Juvenile Justice Amendments of 1980 (P.L. 95-509) modified the title of the Runaway Youth Act to the Runaway and Homeless Youth act, provided that grants be made equitable among the States based upon their respective populations of youth under 18 years of age and authorized the Secretary to fund a National Communications System. This system provides referral and crisis intervention services to runaway and homeless youth and families through a toll free hotline. During FY 1984, the legislation was extended through FY 1988 by P.L. 98-473.

Expectations for this Act are: to alleviate the problems of runaway youth; to reunite children with their families and to encourage the resolution of intrafamily problems through counseling and other services; to strengthen family relationships and to encourage stable living conditions for youth; and to help youth decide upon a future course of action (U.S. DHHS, "Runaway," 1988).

Youth receiving services under the Runaway and Homeless Youth Program, include the following categories: 1) youth who leave home without permission from parents or legal guardian; 2) youth who leave home as the result of parental encouragement or direction; 3) youth who leave home with the knowledge and the agreement of their parents or legal guardians; 4) youth who are still living at home but who are considering leaving home without the permission of their parents or legal guardians; and 5) youth who are living in an unstable or critical situation, but who are not planning to leave (U.S.DHHS, "Runaway," 1988).

REASONS FOR SEEKING SERVICES

Several reasons have been advanced as to the causes of leaving home. Loppnow (1985) noted an evolution of explanations for running away with earlier articles reflecting the traditional psychopathological school of thought which attributed running away to individual pathology or dysfunction such as poor impulse control, low frustration tolerance, poor self image, or poor judgement. He found that recent literature reflected a shift to an environmental context in which the reasons for running away were likely to be attributed to situational factors outside the individual adolescent, such as family dysfunction or abuse and neglect.

The causes of these youth problems are complex, multiple, and interrelated. Loppnow (1985) reports that the features most often associated with running away are inadequate parent-child relationships and stressful home environments. The major reasons cited by youth for seeking services are: relationship with parents (66.1%); other personal problems (13.9%); family crisis (8.7%), Juvenile Justice System (4.6%); school, relationship with other youth and law enforcement (6.7%). Fifty-five percent of youths seeking services reported reasons associated with poor communication with parents, and 30% reported that their parents were too strict.

In some cases, "running away" is the only solution imaginable to the adolescent to escape from what seems an unmanageable problem, either with parents who may place inappropriate burdens or expectations on the young person, with school and peers, or with others in his or her environment.

INCIDENCE OF RUNAWAYS

The Department of Health and Human Services (U.S. DHHS, "Runaway," 1988) estimates that the number of runaway youth in the nation, ages 10-17, is more than one million in the course of a year. This figure is based upon the 1976 National Statistical Survey of Runaway Youth, and updated based upon the estimates of knowledgeable experts in the field of youth services.

During FY 1986, DHHS-funded centers for runaway and homeless youth provided residential or walk-in services for a total of 339,400 youth roughly the same as the number served in FY 1985. An estimated 65,400 youth received shelter or ongoing services which is comparable to the FY 1985 figure (U. S. DHHS "Runaway," 1988). In addition, over 2.5 million callers have received services including crisis counseling, information and referral, and message delivery, since 1975.

DISPOSITION OF YOUTHS RECEIVING SERVICES

Fifty-three percent of the youth receiving ongoing services were reunited with their families or guardians, 35 percent were placed in other appropriate alternative living arrangements, 6 percent had no planned destination, and approximately 6 percent of the youth served returned to the streets (U.S. DHHS, "Runaway," 1988).

CHAPTER 9

ADOLESCENT ACCESS TO CHILD WELFARE SYSTEM

FACTORS THAT ENHANCE ACCESS TO CHILD WELFARE SERVICES FOR ADOLESCENTS

There are a number of factors which have enhanced access and the likelihood of adolescents receiving services in the child welfare system. These are the result of: 1) revised juvenile codes, and 2) creation of new and innovative programs which are aimed specifically at the 10 to 18 year old age group.

Revised Juvenile Code

The revision of statutes affecting juveniles has in many states removed status offenders from the jurisdiction of the juvenile justice system, and designated child welfare agencies as having the responsibility for provision of services for these youth. This has meant that youth who are in conflict with their families, drop out of school, or run away may become the responsibility of child welfare services. The new and challenging demands of these youth have given rise to the development of some new and innovative programs within the child welfare system.

New and Innovative Programs

Many of the new and innovative programs operated by private non-profit with the support of demonstration grants from federal, state, and local agencies which promote and support child welfare services. These programs include teen drop in centers, shelters for runaway and homeless youth, sexual abuse prevention and victim assistance programs, and teen pregnancy programs (including programs for teen fathers as well as for mothers). These programs often are voluntary and only reach a small percentage of adolescents who have the problems for which they are providing services. There are no data available that evaluate these programs on a national level.

Several other changes in the child welfare system present more difficulty in determining impact on access to the system. These include the separation of child welfare programs from public assistance programs and the increased use of guardian ad litem and Court Appointed Special Advocate Programs (CASA).

The CASA and Guardian ad litem programs have been established to represent the best interests of children in out of home placement decisions and in abuse and neglect proceedings (Wolff & Longino, 1986). As of November, 1986, there were 213 programs in 43 states, with a total of more than 8,000 volunteers trained to serve the court as investigators, advocates, facilitators and monitors for abused and neglected children. There are no data available regarding the ages of the children and youth served by these programs, but certainly adolescents are among those who have benefited from these services.

FACTORS WHICH INTERFERE WITH ACCESS TO SERVICES WITHIN THE CHILD WELFARE SYSTEM

Federal and state laws and policies are the determining factors for adolescents being eligible for services within the child welfare system. Once accepted for services, these laws and policies as well as local agency and judicial practices also influence where in the system adolescents will be served, if at all. In addition, continual changing of who has responsibility for specific clients as well as problems in coordination between service sectors, such as the juvenile justice and mental health systems, also make it difficult to predict how adolescents with problems will be served.

Other factors which limit access of adolescents to child welfare services include their likelihood of receiving low risk ratings and their potential for taking matters into their own hands by running away or refusing service options. The remainder of this section will discuss these factors.

Risk Assessment

Many states have moved to a risk assessment model for screening and determining priority for cases referred to child protective services. Since adolescents are often deemed more able to protect themselves, they are likely to receive lower risk ratings on such scales than younger children. This leads to a lower priority for scarce casework or supportive services for this population.

Difficult to Manage Behaviors

Adolescents who come to the attention of child welfare services are likely to do so after many years of maltreatment. The behaviors of these youth, as described earlier are often characterized by difficulties, including aggressive or illegal activities, and long standing history of failures. In many states, there is a very fine line between those youth who end up in child welfare services and juvenile justice or mental health services. The child welfare system may try to restrict involvement with those youth whom they see as potential clients for the juvenile justice or mental health system and pressure these providers to serve them. Child welfare services may be reluctant to become involved with youths who are known to be involved in violent or illegal activities such as street gangs, prostitution, or drug use. In addition, there are increasing numbers of adolescents who in the past might have been served by child welfare agencies who are now living on the street. Only a small proportion of these populations use runaway and homeless youth shelters. There is no way to determine the numbers of these youth but they are visible on the streets of many urban cities, especially those in coastal areas. The movie "Street Wise", (1986), documents the story of some of these youth in Seattle, Washington.

Limited Inter-Agency Efforts

Another barrier to the use of child welfare services by adolescents is the lack of relationship between child welfare services and public schools, the agency in the community system which has the most contact with adolescents. In the past, schools interacted with youth serving agencies through truancy officers. In most states in the past 10 years, there has been a revision of the juvenile codes, which has resulted in the removal of truancy as a legal offense which could be brought to the attention of either the juvenile justice or child welfare systems. This has led to increased numbers of youth not being identified as in need of services and has contributed to the number of street youth.

Increased Prosecution of Sexual Offenders

In many areas, there has been an increase in efforts to prosecute sexual offenders. This has affected adolescent access to child welfare services in several ways. First, those youth who are both victims and perpetrators of sexual abuse may now be dealt with in the adult criminal justice system rather than the juvenile justice system. Juvenile sex offenders are not routinely screened to determine if they are themselves victims of child sexual abuse and therefore may be prosecuted without any involvement of the child welfare system even though as victims they are entitled to these services.

Second, as more cases of sexual abuse are prosecuted, involvement with adolescents who have been victims of sexual abuse may shift towards greater emphasis on collecting evidence in order to prosecute the offender rather than to provide services for the abused. For example, programs for sexual offenders in Seattle are housed in the juvenile court. Entry into these programs is determined by court findings of evidence of commission of an offense.

Lack of Residential Alternatives

As has been described earlier in the paper, many adolescents who come to the attention of child welfare agencies have behaviors which are difficult to deal with. Often, foster parents lack the skills or abilities to manage difficult adolescent behaviors. Kamerman & Kahn (1989) report that foster care was significantly downgraded in the 1980s and recruitment of foster parents is a major problem.

Youth needing help are increasingly those who have been in a variety of community resources already, have major problems in functioning in relation to their parents and are unlikely to manage in a foster home any better than they have in their own homes (Kamerman & Kahn, 1989). Often they are chronic runaways and have been physically or sexually abused when younger. Kamerman & Kahn (1989) state that there is need for an alternative to both traditional foster family care and institutional care. They suggest group homes for adolescents, residential treatment facilities of several kinds, and facilities for acting out youth and for those who are mentally ill.

CHAPTER 10

CHILD WELFARE PROGRAMS THAT WORK FOR ADOLESCENTS

There are a number of exemplary programs for adolescents in child welfare services which are presenting innovative approaches. These programs are targeted towards assisting runaway and homeless youth, youth emancipating from foster care, pregnant and child rearing teens in foster care and other teens who need help. Some of these programs cannot be labeled solely child welfare programs, that is, they are also supported by other sectors of the system of services such as mental health, public health, juvenile justice and education.

Most of these exemplary programs have been developed on a local level and have not yet been replicated in other areas. The diverse nature of the programs along with the diverse population of adolescents they are serving makes it difficult to evaluate these programs on a national level. Two programs that serve adolescents in several states will be briefly discussed in this section.

THE CASEY FAMILY PROGRAM

The Casey Family Program was established as a privately endowed social service agency to provide quality long term foster care for children and youth when this is the best permanent plan. It has endeavored to use foster family home placement in more creative ways for a challenging population of children (Fanshel, Finch, Grady, 1989). It utilizes many support services for these children and provides foster families with a significantly higher reimbursement than public and most non-profit child welfare foster care agencies.

Fanchel et al. (1989) will be releasing data from a study of 585 children who were in placement with The Casey Family Program from 1966 through 1984. The authors state that their findings have policy implications for children whose needs are not adequately recognized nationally.

HOMEBUILDERS

The Homebuilders Program began in Tacoma, Washington, in 1974. It provides intensive in home services in response to crisis situations referred by child welfare, mental health or juvenile justice programs. About two thirds of the children who are referred to The Homebuilders Program are between eleven and fifteen years of age. In addition to working with schools, courts and other youth serving agencies, the Homebuilders therapists often get involved in the provision of practical help such as cleaning the house or fixing the car.

Peter Forsyth (1989), Director of the Edna McConnell Clark Foundation, reported a success rate of 80% for the Homebuilders service. Success was determined by the number of children still in their homes three months after they had received the services.

CHAPTER 11

EFFECT OF FEDERAL PROGRAMS AND POLICIES ON GAINING ACCESS TO CARE BY ADOLESCENTS

There have been two major federal mandates in the past 10 years which have influenced access of adolescents to child welfare services. These are the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and the Independent Living Initiative under the federal Title IV-E Foster Care Program enacted in 1986 (P.L. 99-272).

ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980 (P.L. 96-272)

The principal goal of permanency planning according to the Adoption Assistance and Child Welfare Act of 1980 is to reduce the number of children in state custody by: 1) curtailing the entry of children into the foster care system by providing preventive services; 2) providing reunification services for the children and their birth parents; and 3) closing cases rapidly via relinquishment for adoption and placement with permanent adoptive parents. While there are some positive benefits in the emphasis on the importance of family ties in long term planning as well as it making more services available for families, this emphasis has also led to difficulties when adolescents are involved.

Although P.L. 96-272 was intended to decrease out of home placements by emphasizing family preservation and permanency planning a negative side of this law for some adolescents has been limited options to remaining in or returning to settings which are abusive (Loppnow, 1985). Preventing out of home placement is also difficult for some adolescents who enter foster care because of their behavior problems rather than because of inadequacies in the home (Barth, 1986). For adolescents who have grown up in foster care, relationships with birth parents are often nonexistent and reuniting adolescents with their birth families is difficult to achieve (Barth, 1986). Generally, youth who have been subjected to chronic abuse will require long-term treatment and the usual goal of returning home may be problematic (Loppnow, 1985). By contrast, where nonchronically abused adolescents are involved, a short-term crisis-oriented approach may be more appropriate (Loppnow, 1985).

The emphasis on adoption when family based services are exhausted or have failed may not be appropriate for most adolescents. Since neither family reunification nor adoptive placement is always feasible for adolescents, the majority of these youths pass their 18th birthday, at which point they are no longer eligible for care and have few personal or social resources for independent living (Timberlake, Pasztor, Sheagren, Clarren, Lammert, 1987). While there has been some evidence that permanency planning efforts have at least stopped the increasing rate of out of home placements (Hill et al., 1987), it is not known at what cost this has been done, i.e., have some youth been forced to remain in homes where they continue to be physically, sexually or psychologically abused.

Barth & Berry (1987) have assessed available research on outcomes of child welfare services under permanency planning. Indicators of placement outcome included abuse, placement stability, developmental outcomes, and children's satisfaction with the placement. They concluded of all placement options, in-home services or reunification with birth families failed most often to be free from abuse and to yield developmental well-being. Breakdown of ages were not available.

Another undesirable consequence of this legislation has been the significant reduction of the autonomy traditionally granted to practitioners to make individualized, professional judgments about the service needs of children in care (McGowan & Walsh, 1985). Findings from a study conducted at Parsons Child and Family Center in Albany, New York by Reid et al., (1987) suggest that the notion of "permanence" needs to be rethought when it applies to adoptions of disturbed older children. They state that the youth who "permanently" leaves the child-care system is primarily indicative of the agency's or community's success in avoiding lengthy institutional placements and is not necessarily a measure of the quality of the adoptive experience for the youth or the adoptive family.

INDEPENDENT LIVING INITIATIVE OF 1986
(P.L. 99-272)

In 1986 the Independent Living Initiative of the federal Title IV-E Foster Care Program was established as a part of P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985. This Act entitled states to funds to be used for a variety of activities and services to assist eligible children make the transition from foster care to independent living. Children eligible for this program must be 16 and over and have Title IV-E foster care maintenance payments made on their behalf. Since these are recent programs no data are yet available on the numbers of youth served or the outcomes of services.

The activities and services for which these funds were designated include:

1. Appropriate support to enable participants to seek a high school diploma or its equivalent, or to receive vocational training;
2. Training in daily living skills, budgeting, locating, and maintaining housing, and career planning;
3. Counseling for individuals and groups;
4. Integrating and coordinating services otherwise unavailable to participants;
5. Providing for the establishment of outreach programs designed to attract individuals who are eligible to participate in the program;

6. Providing each participant a written transitional independent living plan based on an assessment of his needs, and which shall be incorporating into his/her case plan.

Other federal programs which have had an impact on adolescents' access to child welfare services are included below.

POST ADOPTION SERVICES

Federal emphasis on adoption services has included an increase in availability of services for those adolescents who were adopted, and whose families are experiencing difficulties in managing them.

ADOLESCENT DRUG AND ALCOHOL TREATMENT PROGRAMS

Federal support is available through Medicaid for use of these programs by adolescents who are in child welfare services.

ADOLESCENT ACT

This act has limited counseling and other services available for pregnant adolescents. This has increased the emphasis on adoption as the preferred alternative for pregnant teens, and has restricted access to abortion counseling and family planning information.

CATEGORICAL PROGRAMS WITHOUT EFFECTIVE INTER-AGENCY AGREEMENTS AND PROGRAMS

The programs which provide services for adolescents on a federal, state and local level continue to be categorical and fragmented. The same adolescent may be served sequentially or simultaneously by the child welfare system, mental health, juvenile justice system, public health, and public education systems with no mechanisms for collaboration or cooperation existing between these systems. There are a number of federally and state funded initiatives which, on a pilot basis, are attempting to address these issues. However, these programs are most often funded for a short duration with inadequate or no funds for implementation within the larger systems.

In summary, there appears to be a lack of awareness or priority on a federal level for the inclusion of adolescents in a systematic and meaningful way in many programs in the child welfare system. Adolescents continue to be the "throw aways" of Schorr's (1988) "children of the shadows."

CHAPTER 12

EFFECTIVENESS OF CURRENT CHILD WELFARE SYSTEM

It is difficult to evaluate the effectiveness and appropriateness of the current child welfare system for youths ages 10 to 18 because there are often no breakdowns by age and little longitudinal data. Many existing studies collected data on cases prior to full implementation of The Adoption Assistance and Child Welfare Act of 1980. Therefore, the effects of this legislation are not yet known.

There are no national data regarding the supply of services, the interventions used, or the characteristics of providers, or are there data on the characteristics and numbers of children in each part of the system (Kamerman & Kahn, 1989). Additional problems in evaluating the effectiveness of the child welfare system stem from the lack of standardized definitions as well as the lack of comparable state expenditure data or adequate federal data collection. There is also no accurate way to determine the number of adolescents who could be receiving child welfare services by virtue of their needs but who are living on the street and unknown to service providers.

CHAPTER 13

GAPS IN SERVICES TO ADOLESCENTS

A number of health and developmental issues have been described in the sections on substitute care, protective services and runaway youth. In addition, sexuality, family planning, education and emancipation issues often arise for adolescents in child welfare services.

SEXUALITY - FAMILY PLANNING SERVICES

Access to appropriate information on sexuality and family planning services is difficult for most adolescents and particularly difficult for adolescents in foster care. There is a lack of clarity as to who is responsible for educating adolescents in care about sexuality, whether the foster parent, other care provider, caseworker, school counselor, or natural parent should provide information concerning sexuality and sex education to the adolescent (Children's Defense Fund, 1987).

According to Polit, White and Morton (1987) no state maintained information records data about child welfare clients sexual activity, pregnancy history or outcomes, or use of family planning and related services.

EDUCATIONAL NEEDS

There is very little information regarding the educational needs and problems of children that result from abuse, neglect, and multiple placements. Youth who have been neglected or abused as infants may show deficits and delays in motor development, language development and social skills, and show various learning difficulties (Steele, 1987). Although they may require special educational help, the school system is usually unaware of the abuse background which may be the origin of the behavioral and learning difficulties of these children.

The over all educational attainment of children in out-of-home care is dismal (USRE, 1987). Over half of the children in this study were performing below grade level in both reading and mathematics.

The most complete data on the specific needs of youth in foster care come from studies of adults formerly in the system. The most significant finding in these studies is that youths in foster care do less well in school than the general population. Two longitudinal studies of foster care youths, one done in New York (Festinger, 1983) and New Orleans (Zimmerman, 1982) showed youths as having significant problems with school work at the time of discharge.

EMANCIPATION - INDEPENDENT LIVING

Children who are discharged to their own supervision and who are expected to assume full adult responsibilities at the age of majority (typically 18 years) need assistance in making the transition to independent living (Barth, 1986). The author states that these youth have no guarantee of support from adults for getting settled in worlds of employment, higher education, housing, and child care. Barth (1986) reviewed studies of outcomes of adolescents emancipating from foster care and found continued contact with foster parents and birth parents improved the outcome for foster youths. He found educational and employment deficits were the most troublesome for foster children to deal with as adults.

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CHAPTER 14

DISPOSITION OF CASES

Disposition and outcomes have already been described for child protective services, substitute care services and runaway youth in thee respective sections. A number of factors including the point of entry of the case (i.e., through protective services, foster care, public or private agencies, state laws, agency policies and procedures and judicial and court precedence are important components of disposition. The Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272 has been described in a previous section and sets forth federal guidelines which provide the basis from which these practices are derived.

The National Council of Juvenile and Family Court Judges have developed training materials which include a "Judicial Review of Children in Placement Deskbook" (Praksti, 1986). This "Deskbook" is a comprehensive and practical manual which is intended to aid in the implementation of Public Law 96-272. It includes:

1. The Procedural Matters Checklist which focuses on how cases come before the court for review, and includes a summary of

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jurisdictional matters which enables the court to properly hear a review.

2. The Substantive Matters Checklist which is divided in to two separate sections. The first section addresses the issues to be examined during the first review hearing. The second section discusses the parties' understanding and performance of their obligations under the case plan and the appropriateness of the plan.
3. The Court and Social Service Agency Checklist discusses cooperation and coordination between social service agencies, the juvenile court and interested parties.
4. The Prevention and Reunification Checklist provides information on the federal mandate requiring a judicial determination that reasonable efforts be made to prevent the placement of a child in foster care or to reunify the family of a child already in placement and a protocol to enable the court to make such a determination.

There is no information available on the ways in which these points may be applied to children and youth of different ages.

CHAPTER 15

INTERFACE OF CHILD WELFARE SERVICES WITH OTHER AGENCIES

Child welfare services have often been isolated from other service sectors such as juvenile justice, mental health and school programs. Up until about five years ago, they were often administratively housed with general assistance or welfare services. Even though child welfare services are housed within state social and health service agencies, they often do not have interagency agreements or working relationships with other programs serving children and youth such as mental health or developmental disabilities programs (Richardson, West, Day, et al., "Coordinating," 1989; Richardson, West, Day, et al., "Children," 1989). There are frequently disagreements among these state agencies as to whose responsibility it is to serve which youth with which services. Child welfare services are often the "court of last resort" for services for troubled adolescents, and have a limited array of services and programs from which to draw.

The lack of interagency working relationships has also contributed to worker isolation. Child welfare social workers are often not familiar with

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professionals who work in many other community settings such as schools, health clinics, and mental health centers. For example, in a recent study of 150 child protective service cases in Seattle it was found that of those where the child was of school age, there was no school information for 88% of the cases (West, Crimi, Leconte, et al.).

CHAPTER 16

COSTS

There are a number of Federal Initiatives that benefit adolescents who are in need of child welfare services. The major federal funding that affects adolescents is Title IV-E Foster Care Program, Title IV-E Adoption Assistance Subsidy, Title IV-E Independent Living Funds, and the Runaway and Homeless Youth Program. Other programs that benefit adolescents include: Child Welfare Training, Child Welfare Research and Demonstration Projects.

There are two major limitations when one attempts to determine how much of the actual amount is for direct services for adolescents. First, expenditures for children and adolescents are combined so it is not possible to determine what portion is specifically for youths ages 10 to 18; and second, there are not separate totals for federal and state expenditures for services provided to children. For example, the proposed 1990 budget requests for Foster Care, Adoption Assistance and Child Welfare Training are $1,161.2 million, $125.3 million and $3.7 million respectively. Most of the dollars go for staffing State agencies with no distinction between service providers, administrators, supervisors or support staff. To determine what portion of the dollars serve adolescents, one must look state by state to see how their dollars under initiatives have been spent or to review individual discretionary grants that have been awarded under various programs.

Two of the programs are directed towards adolescents: 1) the Independent Living Program (for youths in foster care ages 16 and over) and 2) the Runaway and Homeless Youth Program which serves youth under 18 years of age. The Title IV-E Independent Living Program was extended for three years, through Fiscal Year 1992, and the entitlement ceiling for the program was increased from $45 million to $50 million for FY 1990, $60 million for FY 1991, and $70 million for FY 1992 (Children's Defense Fund, 1990). Congress also required the Secretary of Health and Human Services to study and evaluate the state Independent Living Programs, in order to compare the outcomes for children who have and have not participated in the programs. The appropriation for support of the FY 1986 National Program for Runaway and Homeless Youth totaled $22,231,000.

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Since it is difficult to determine direct service costs to adolescents from fiscal year budget requests a breakdown of costs per child per year are presented below. These figures were obtained from Schorr (1988).

Foster Care- $3,600 - 8,400/year per child
Residential Care- $19,000/year per child
Institutional Care- $64,000/year per child
The Casey Family Program- $19,611/year per child
Homebuilders- average costs: $2,600/treatment

For comparison on a local level, the current rates for substitute care for children living in Washington State are shown below.

Youth ages 6 to 12- $272.46/month 3,269.52/year
Youth ages 12 to 18- $322.18/month 3,866.16/year

An additional $123.60 a month can be paid under special conditions for a special needs child. Beyond this amount, exception to cost placement for individual children based on their needs may be added and can run into thousands of dollars depending on the need. The basic rate for a receiving home is $13.32 per day and higher rates for special needs teenage or a teenage who is a runner is $18.21 per day.

We were not able to do a cost comparison between different types of programs because comparable data are not available. The figures presented above are so general we are hesitant to use them. However, they give a general idea of the variability of costs of programs.

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CHAPTER 17

SUMMARY OF ISSUES AND RECOMMENDATIONS FOR IMPROVED SERVICES FOR ADOLESCENTS IN THE CHILD WELFARE SYSTEM

Throughout this paper many issues and problems relating to services for adolescents in the child welfare system have been identified. Adolescents who are already in the child welfare system, attempting to enter the system, or are eligible but not involved in the system include physically or sexually abused or neglected adolescents, adolescents in conflict with their family, status offenders, runaways, and adolescents who are pregnant or parenting. Adolescents receiving services may be either long-term recipients of child welfare services or only recently in contact with these providers.

It is difficult to determine the number of adolescents who receive child welfare services because of problems in reporting and collecting information. According to available data, approximately half the children in foster care are adolescents and approximately forty percent of the children who are waiting for an adoptive home are adolescents. The estimated number of runaway youth, age 10 to 17 is one million a year. There is no way to determine the number of adolescents who would be eligible for services but are not receiving them.

The child welfare system was originally designed to help state and local agencies provide preventive and protective services for children. It was not designed to serve adolescents with multiple problems. If services to adolescents are given the priority they need, several shifts in the premises of child welfare services need to be considered. First, there is a need to recognize that "child" welfare services include adolescents who because of their developmental status require different policies and a different constellation of services than those which are directed towards younger children. Second, there is a need for the development of services for the increasing number of youth who previously were included in the juvenile justice system as "status offenders" and who are now in most instances coming to the attention of child welfare services.

Thus, there are two sets of issues to address: 1) improving child welfare services for the youth who are receiving them, and 2) developing new and innovative programs for the youth whose needs are not being met.

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The following are our high priority recommendations for improving child welfare services for adolescents:

1. Provide training for child welfare service workers and foster parents on adolescent growth and development.
2. Develop a systematic method to address the health care needs of adolescents receiving child welfare services.
3. Provide coverage for items not currently reimbursed by Medicaid such as counseling for adolescents..
4. Provide SSI coverage for all adolescents who are developmentally disabled.
5. Continue to fund Independent Living Programs so that they are routinely available to adolescents transitioning from foster care to independent living.
6. Address the special needs of minority youth in child welfare services to assist them with language and cultural barriers to use of services.

7. Revise risk assessment procedures so as not to exclude adolescents from child welfare services.
8. Develop a guardianship program for youth who have been or will be receiving long term child welfare services.
9. Address the educational needs of adolescents in order to decrease the school drop out rate for youth in child welfare services.
10. Increase long term out of home placement options beyond the current emphasis on adoption or placement with a relative.
11. Develop a range of group homes which include residential treatment services.

The second set of recommendations addresses the needs of youth not being adequately served:

1. Develop programs for teen mothers with babies who have no place to live.
2. Provide walk in health care centers for adolescents which includes a range of services including family planning.

3. Develop programs for alienated youth and youth with alternative lifestyles...e.g., gay youths.
4. Improve and develop services for the more than two thirds of the estimated one million runaway and homeless youth who are not using shelters.

Adolescents need a broad range of health, developmental, educational, and social services which go beyond the capacity of single agency to provide or even coordinate. Adolescent and family problems do not fall into a single category but rather overlap into multiple service areas including: child protective services, mental health, juvenile justice, and education.

In order to address the diverse needs of adolescents and their families who come to the attention of child welfare services it will be necessary to develop policies, planning strategies and programs that cross agency boundaries. This is not to suggest that agencies should be reorganized but rather to emphasize the importance of collaboration and coordination at all levels from agency administrators to direct service providers. Such an approach to interagency coordination is an important addition to service delivery for those populations who cross traditional agency boundaries. Interagency agreements should be thoughtfully planned and have practical guidelines which include sharing financial and information resources.

There are a number of innovative programs that serve specific groups of adolescents in many cities and states. However, without improvements in interagency efforts, these programs are severely limited in the impact they can have on those adolescents who have complex and difficult to treat problems. Improvements in interagency efforts are essential to providing a solid foundation for services. Without such a foundation programs for hard to serve adolescents are on shaky foundations which may not be able to support new and innovative approaches.

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ADOLESCENT VICTIMS OF MALTREATMENT

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Outline:

Preface

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II. Who Are the Adolescent Victims?

III. Consequences of Adolescent Maltreatment

IV. Adolescent Maltreatment in the Context of Domestic Violence

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Preface: The purpose of this report is to review evidence concerning adolescent maltreatment. Reviewing the large body of research, theory, and clinical evidence concerning child abuse has been the purpose of other reports (including earlier efforts of the Office of Technology Assessment--e.g. Healthy Children-- U. S Congress, 1988). This is not the goal here. Similarly, the Office of Technology Assessment has commissioned a separate report dealing with "The Child Welfare System for Adolescents" (West and Stuart, 1989). The present report is thus circumscribed as to its topic: understanding the dynamics of parental maltreatment involving victims between the ages of 10 and 18. This is done with the recognition that the federal "Child Abuse Prevention and Treatment Act" (Public Law 93-247 as amended) defines child abuse and neglect to refer to "a child under age of eighteen." However, developmental psychologists recognize adolescence as a distinct period in the human life course, with special issues that differentiate it from childhood. What is more, and as shall be seen, there are important practical and policy reasons for considering adolescent maltreatment separately from child maltreatment.

I. INTRODUCTION:

"Adolescent maltreatment" refers to all the various categories of abuse and neglect that are subject to public approbation. Most conventional analyses identify abuse as active assault upon a dependent victim (child, adolescent, spouse, or elder). It is distinguished from other assaults in which the perpetrator does not have responsibility for the victim (e.g., assault by a peer or by a stranger).

These abusive assaults are generally understood to be physical (e.g., beating a ten-year-old child), sexual (e.g., a parent having intercourse with a 13 year-old-daughter), or psychological (e.g. humiliating and belittling a 12-year-old in front of his friends). Thus, professionals generally recognize categories of physical abuse, sexual abuse, and psychological abuse. The same is true for neglect, which refers to acts of omission that include failure to meet basic needs (as defined by prevailing community standards of care at the time of a specific incident). Physical neglect refers to grievous failure to provide physical necessities such as food or clothing. Psychological neglect refers to a failure to provide appropriate supervision (e.g., leaving a

13-year-old alone for days at a time) and the basic emotional responsiveness and stimulation necessary for development (e.g., depriving a 13-year-old of all opportunities to participate in developmentally appropriate social experiences outside the home). Supervisory neglect includes failure to protect a dependent individual from sexual victimization (e.g., permitting a spouse or someone else to molest a 14-year-old daughter or son).

However, these distinctions are often more useful conceptually than they are as descriptions of actual experience. Indeed, any single incident may incorporate all three categories-- e.g., a violent sexual assault that is tolerated by a spouse almost certainly has elements of physical abuse, sexual abuse, neglect, and psychological maltreatment.

What is more, most professionals recognize that rarely does one encounter only one kind of abuse in the life of a youth (particularly if one observes a family over an extended period). The same adolescent who is being sexually abused now may well have been physically attacked (or at least threatened with physical attack), and probably has been emotionally assaulted and neglected as well. Rarely does one kind of abuse -- particularly a pattern of abuse -- occur in the context of an otherwise and previously gentle, loving, supportive, and well functioning family. It does happen, but the general coincidence of various forms of abuse with each other, and with more generalized patterns of family dysfunction lends credence to generally employing the term "maltreatment" to categorize the generic experience of adolescent victims.

The maltreatment of adolescents is linked dynamically and programmatically with a wide range of adolescent problems -- delinquency, parricide, running away, and prostitution, to name just four that are mentioned frequently in research and clinical reports (cf., Garbarino, Schellenbach and Sebes, 1986; Parent, 1979; Blount and Chandler, 1979; Rogers and LeUnes, 1979). The degree of coincidence between maltreatment and each of these problems exceeds 65% in some samples (e.g., most teen prostitutes have experienced abuse and neglect).

Maltreatment is implicated in many adolescent problems. This influence includes both prevalence (many maltreated youth have these problems) and intensity (maltreated youth tend to exhibit the more serious forms of these problems. In the case of runaways, for example, the link is often so clear that one can differentiate among siblings in terms of their experience of abuse and its consequence in serious runaway behavior (Parent, 1979). The more abuse suffered, the more likely the adolescent is to become a serious runaway (i.e., go further away from home and stay away longer) (Parent, 1979).

Similar connections are observed when examining the links between child abuse and subsequent aggressive behavior (Blount and Chandler, 1979; Rogers and LeUnes, 1979). The degree to which these relationships are merely correlational or acutally are causal is not known definitively. Kids from abusive families are more aggressive than others, and those who have experienced the most abuse tend to be most aggressive. These links provide an important aspect of the context within which we must understand adolescent maltreatment, and one to which we shall return. A second aspect of that context is public and professional stereotypes about adolescents.

Negative stereotypical images of adolescence contribute to the context in which the dynamics of adolescent maltreatment takes place, and in which those who would deal with it must operate. These images find their professional parallel in the widely-held image of adolescence as necessarily "stormy and stressful" ("Sturm und Drang") (Garbarino, Kelley, & Schulenberg, 1985; Kelley & Garbarino, 1985). In this view, popularized by Stanley Hall in the early years of the twentieth century, adolescents experience conflict and turmoil as a normal part of their development. Many who hold this view most strongly have studied or worked professionally with disturbed adolescents engaged in deviant behavior.

Along these lines, Anna Freud (1958) wrote of the difficulty of distinguishing normality from psychopathology in adolescence:

> ...adolescence constitutes by definition an interruption of peaceful growth which resembles in

> appearance a variety of other emotional upsets and structural upheavals. The adolescent manifestations come close to symptom formation of the neurotic, psychotic or dissocial order and merge almost imperceptibly into borderline states, initial, frustrated or fully fledged forms of almost all the mental illnesses. Consequently, the differential diagnosis between the adolescent upsets and true pathology becomes a difficult task." (p. 267)

Anna Freud viewed adolescence as a developmental disturbance derived from the reawakening of libidinal impulses that marks the movement from the latency period into the pubertal period. Teenagers experience psychic conflict as they try to balance their Oedipal impulses with what society dictates as correct behavior. Childhood defenses (repression, rationalization, and projection) keep these Oedipal desires from awareness, and thereby permit escape from uncomfortable and threatening turmoil.

As the individual matures, this defensive balance ("preliminary and precarious" as it is) becomes more and more inappropriate. It can't handle the powerful sexual drives that are resurgent in adolescence. Adolescents must overthrow their old systems and build new ones. This process results in the rebellion, the ups and downs, and the dramatic changes that Anna Freud saw as being typical of adolescence.

According to this psychoanalytic view, the "period of upheaval" is a healthy, normal expression of development. However, during pubert adolescents will reject their parents (in response to the unacceptable desire to possess the opposite sex parent), and enter into a series of intense but brief romantic involvements with their peers (as they learn to accept and adapt to their new-found sexuality). As we shall see, this professional orientation is an over generalized stereotype, but one that resonates with popular images among the lay public.

Some of the most prominent observers of adolescence in the 1950's and 1960's saw negative stereotypes of youth as both the cause and effect of adolescent alienation from the adult world. Classics such as Paul Goodman's Growing Up Absurd (1956) and Edgar Friedenberg's The Vanishing Adolescent (1959) and The Dignity of Youth and Other Atavisms (1965) explored this theme.

In her book Children Without Childhood (1983) Marie Winn speaks of "The Myth of the Teenage Werewolf:"

> A pervasive myth has taken hold of parents' imagination these days, contributing to their feeling of being powerless to control the fates of their children: the myth of the teenage werewolf. Its message is that no matter how pleasant and sweet and innocent their child might be at the moment, how amiable and docile and friendly, come the first hormonal surge of puberty and the child will turn into an uncontrollable monster.

(p. 14)

From Anna Freud's psychoanalytic perspective, the exhibition of "storm and stress" in the form of conflict with parents is not only a natural experience but it is also a necessary occurrence for normal adolescent development to occur. The "upholding of a steady equilibrium during the adolescent process is in itself abnormal." (A. Freud, 1958, p. 275). This may lead adults both withim and outside the family to miss the significance of "acting out behaviors" adolescent may display. These behaviors are most appropriately seen as indicators of disrupted development, family conflict, or psychopathology.

Thus, the stereotype of adolescents as troubled and bothersome may undermine our ability to deal with adolescent maltreatment by casting its results as "just a phase," when in fact it is a genuine crisis. Dealing with adolescent maltreatment may depend upon our ability to take seriously its consequences and origins.

But is the storm and stress view correct? Anthropologists such as Margaret Mead and Ruth Benedict challenged it on the basis of their observations in other cultures. Survey research in the United States indicates that while adolescence is usually a time of family challenge adolescents are not normally either crazy or highly rebellious.

The first systematic evidence that teenagers in modern Westernized societies do not necessarily experience major problems of adjustment was presented by two sociologists, Westley and Elkin (1956). Their small sample of middle-class adolescents in Montreal, Canada, reported little turmoil. Instead, they presented a picture of relative calm and stability. Douvan and Adelson (1966) conducted a study in which they extensively interviewed over 3,000 adolescents. The sample was constructed in such a way as to be representative of the entire United States population of boys and girls facing adolescence, although it was restricted to teenagers in school and somewhat underrepresented low income and racial minority youth. In this broad, more representative sample, there also was little evidence of major turmoil and conflict.

Douvan and Adelson's study was criticized for the fact that their interviewers were not mental health professionals (and thus presumably were more likely to miss signs of distress), but subsequent studies that have employed mental health professionals interviewing non-patient populations have confirmed the finding that the majority of adolescents do not show overt signs of disorder. (Of course, the psychoanalytically-oriented might respond that this shows that most adolescents suffer from the "problem" of no problems).

One of the most extensive early studies of adolescent normality was the Normal Adolescent Project carried out by Daniel Offer and his colleagues (Offer, 1969; Offer & Offer, 1973, 1974, 1975). Offer directed an eight-year project using a sample of 73 middle-class, male teenagers in the Midwest United States. The boys were assessed at various times from their freshman to senior years of high school. The assessment procedure consisted of parent interviews, psychological tests, and psychiatric interviews. In addition, 61 of the original 73 subjects were assessed in the same manner during their four years of college (and this reference to college attendance indicates the relative affluence of the sample).

Offer and his colleagues identified three major patterns of growth for these adolescents. "Continuous growth" refers to a gradual, smooth transition from adolescence to young adulthood, free from the turbulence and turmoil predicted by the "storm and stress" theorists. "Surgent growth" refers to a less gradual developmental pattern, where growth occurs in "spurts," between which development appears arrested. Most of the teenagers in this study developed in one of these two modes -- experiencing little stress and discomfort on their way to normal, adaptive adjustment to adulthood. A third pattern of growth was termed "tumultuous growth." It corresponds to the kind of inner turmoil and crisis the storm and stress hypothesis predicts for all adolescents. Twenty-one percent of the sample evidenced this kind of developmental process, This is a large enough minority to sustain the professional stereotype of storm and stress among those who are disposed to do so. But it is but too few to validate empirically the claim that storm and stress is the typical adolescent pattern.

In another study, Rutter, Graham, Chadwick, and Yule (1976) studied a large representative sample of all of the 14-15-year-olds on the Isle of Wight (in Great Britain). They found only a very slight increase in psychopathology from middle childhood to adolescence, and a very low incidence of rejection or relationship difficulties between adolescents and parents. Interestingly, however, they found that about 22% of their sample reported that they _often_ felt miserable or depressed, and were having trouble sleeping.

This is almost the exact percentage that reported this pattern in the studies by Offer (Offer and Offer, 1975). (About 44% reported feeling miserable and depressed _at times_). We should note that in Michael Rutter's study (1976) the incidence of psychopathology (as assessed by a formal psychiatric interview) was 16.3% among their sample, so that there is a difference between reporting depression and being considered clinically depressed.

Therefore, we have evidence from two significant studies that about 20% of adolescents report experiencing serious turmoil as they grow up. This is far short of the majority predicted by storm and stress theorists, and it tells us that we should be alert to families that are experiencing a high level of conflict, for it is not typical or "normal" to do so.

In a survey of college students, Balswick and Macrides (1975) found that only 22% reported that they had been rebellious as teenagers. In their study of middle-class families of adolescent boys, Bandura and Walters (1963) also found little evidence of storm and stress. When teenagers did exhibit aggressive behavior, such as fighting physically with their parents, it was found that these kids presented the same problems as children. The difference was that when they became bigger and stronger could they overpower their parents, a finding to which we will return. Bandura and Walters concluded: "Our findings suggest...that the behavioral characteristics exhibited by children during the so-called adolescent stage are lawfully related to, and consistent with, pre-adolescent behavior" (Bandura and Walters, 1963, p. 196). Subsequent research tends to confirm this conclusion (Ebata, 1986).

The general conclusion is this: profound conflict and turmoil across all life's domains is not the typical pattern of development for adolescents. This conclusion receives support from other studies of non-clinical populations (Grinker, Grinker & Timberlake, 1962; Hamburg, Coelho & Adams, 1974; Oldham, 1978; Weiner, 1970). It seems fairly well established then that when one looks at the data, the typical adolescent is not one who is experiencing far-reaching psychic disturbance as a matter of predetermined developmental course.

We must keep in mind also, that no period in the human life course is totally free from stress and conflict. Adolescents certainly have no monopoly on storm and stress, no more so than toddlers or adults. All this tells us that seriously troubled youth should be taken seriously, and that the behaviors often identified as symptoms of adolescent maltreatment are usually indicators of genuinely serious problems, often problems of family breakdown associated with the special challenges of adolescence. This is the context in which to examine the victims of adolescent maltreatment.

II. WHO ARE THE ADOLESCENT VICTIMS?

To label a pattern of behavior as "maltreatment" is to make a social judgment (Garbarino and Gilliam, 1980; Garbarino, Guttmann, and Seeley, 1986). It is to assert that a particular pattern of behavior is inappropriate and puts the "victim" at-risk for impaired development. There is no objective reality to the concept of maltreatment apart from the historical process in which negotiated settlements between science and culture, professional expertise and community standards, arise, are affirmed, revised, reconsidered, and reaffirmed. Both science and culture evolve. The concept of maltreatment is thus intrinsically social (and historical) in nature. What then was acceptable may now become redefined (or "discovered to be") inappropriate and damaging. The social meaning (and consequences) of objective events changes. A broken arm is a boreken arm, but the public response to the events cauing the fracture are subject to contextual interpretation.

Whereas once it was entirely appropriate to transport a young child on the front seat of an automobile, it is now defined as an act of neglect in some jurisdictions to do so. A generation of improved scientific knowledge and professional expertise has provided the basis for child advocacy aimed at altering community standards of care. The result is a redefinition of "neglect" that is gaining community acceptance and legal validation.

By the same token, expectations for academic attainment for American youth have risen in the last four decades (recall that prior to World War II only a minority of youth graduated from high school). With this changed community standard has come increasing emphasis on "educational neglect." As we shall see, this category alone accounts for a substantial proportion of adolescent maltreatment cases--36% of *all* cases ages 12-17 according to one national survey (NCCAN, 1988). It is within this fundamentally social process of definition (i.e., that defining maltreatment is an act of science-based advocacy) that we must understand adolescent maltreatment. We start from the proposition that adolescent maltreatment only exists insofar as advocates articulate, stimulate, and nuture a community-based standard of care. Like it or not (and some professionals are very uncomfortable with this concept), this is the way things operate in the world of protective services.

Research on adolescent maltreatment is limited to a relatively small number of small-scale studies and several major surveys. Before examining what this small body of research can tell us about who are the adolescent victims of maltreatment, it is worth cataloging the available data sources. Table 1 outlines these studies in terms of sample size, age, types of maltreatment included, and measures used.

---Table 1 here---

The surveys are the National Incidence Study conducted in 1979 and 1985, the American Humane Association's annual tabulation of reported cases (through 1986), and the two national probability samples assessed for domestic violence conducted by Straus, Gelles, and Steinmetz in 1975 and Straus and Gelles in 1985. The small-scale studies include clinical and questionnaire studies of identified or suspected cases of adolescent maltreatment (see Garbarino, Schellenbach, and Sebes, 1986, for a complete review prior to 1986).

In the mid 1970's, the National Incidence Study collected data on suspected abuse and neglect which occurred in a sample of 26 U.S. counties located in 10 states (National Center on Child Abuse and Neglect, 1980). In addition to child protective service agencies, other local agencies were surveyed (including schools, hospitals, police, and courts). The study used a set of clear (although from some points of view debatable) criteria for including cases in the data set. It dealt with all forms of maltreatment -- including "educational neglect," a somewhat controversial category that accounted for a large number of the cases (particularly for adolescents).

This approach resulted in the identification of what would be projected nationally to be approximately 650,000 distinct cases. This study was replicated in 1985, with some additions and revision in the design and methodology, designed in part to respond to objections raised to the earlier effort (National Center on Child Abuse and Neglect, 1988). This replication produced an estimate of 1,025,900 cases (using the same definitions used in 1980). It must be noted that the National Committee for Prevention of Child Abuse commissioned an in-depth analysis of the statistical reliabilty and validity of the sampling approach used by the NIS and concluded: "Despite the problems raised by the reviewers, both of the National Incidence Studies utilized justifiable methods and generated estimates, which if one accepts the majority of the assumptions made in the course of developing the study design, are as credible as anything currently available. However, the vast number of assumptions underlying the development of national estimates using the present methodology and the inabilty to quantify the direction and the size of the total bias resulting from each of these assumptions requires a tremendous leap of faith in accepting the final incidence figures as accurate" (p. 12).

For approximately a decade beginning in the mid 1970's, the American Humane Association's National Study of Child Abuse and Neglect Reporting tabulated and analyzed cases reported to (and "accepted" by) official child protective service agencies, wioth all the possible biases and errors associated with such data. The reports are compiled on a state by state basis and approximately 80% of the states participated in the program. The Study has provided annual tabulations and classifications of reports plus some occasional analyses that shed light on child-adolescent contrasts. This data source has the virtue of being broadly representative and covering a long time period. However, it is limited by the factors that limit the validity and informational quality of the state and local child protective service units who compile and pass along the original data, limitations which are quite significant in some locales where data collection is sometimes slipshod, and which may include biases leading to underreporting of some families (particularly affluent families).

In the mid-1970's, Straus, Gelles, and Steinmetz (1980) assessed the level of violence --including physical abuse-- in a national sample of more than 1000 U.S. families that contained two adults (one of whom was a parent) and at least one child three years of age or older in the mid 1970's. This survey was replicated in 1985 (with some differences in sampling approach and survey methodology, e.g., including a sample that was larger, that included one parent families, that oversampled from Blacks to permit reliable racial comparisons, which included children younger than 3 years of age, and utilized phone interviews instead of face to face interviews as was done in the earlier effort (Straus and Gelles, 1986).

Both studies included measures of both physical abuse and "normal" violence as well (i.e., violence --such as spanking-- which would not be commonly defined as abusive in most communities in the United States). Reliance of these surveys on self-admission has been a source of criticism, particularly with respect to any changes observed over time (with the hypothesis being that any changes might reflect growing public awareness of the deviance of maltreatment, and thus a bias against admitting it in the course of such a survey).

In addition to these large scale national surveys there are a handful of small scale studies that serve to illuminate adolescent maltreatment. Berdie and her colleagues (1983) studied 163 families from two separate samples. The subjects were being served by specialized adolescent maltreatment programs. Farber and his colleagues (1984; 1986) studied 77 families in which an adolescent was being served by an adolescent maltreatment demonstration treatment project. These adolescents had been identified by a local protective service agency (40% of the sample), a runaway youth center (31%), a hospital abuse team (20%), or some other agency (9%).

Garbarino and his colleagues (1980; 1984) studied two samples: 209 cases of maltreatment-- all forms-- (100 of which involved adolescents) reported to a local child protective service agency, and 62 families representing a spectrum of adolescent adjustment problems (22 of whom were later judged to have experienced maltreatment). Libby and Bybee (1979) studied all 25 cases of adolescent physical abuse reported to a local child protection agency over a ten-month period. They excluded all sexual abuse cases from the analysis. However, it is safe to assume that cases of psychological maltreatment coincident with the physical abuse were also present (as they would be in virtually any study that included only physical abuse and did not specifically rule out the coincident presence of psychological maltreatment).

Lourie (1977) surveyed 258 cases of physical abuse and conducted an in-depth clinical assessment of 70 of the cases of confirmed adolescent abuse reported to a local child protection agency. Pelcovitz and his colleagues (1984) studied 33 adolescents (from 22 families) reported to a local child protective service agency and referred to a hospital-based treatment program. Powers and Eckenrode (1988) analyzed cases reported to protective services in New York State, and Garbarino and Kostelny (1989) have analyzed cases reported to protective services in Chicago. In addition, Galambos and Dixon (1984) have examined the dynamics of adolescent maltreatment in terms of the development of personal control.

The large scale surveys and the smaller studies begin to map the social terrain of adolescent maltreatment -- typically classified in tabulations as youth between the ages of 12 and 17. One feature of this is the background provided by age-related trends in the overall exposure of children and youth to assault at the hands of their parents ("corporal punishment").

The survey conducted by Straus and his colleagues offers such a picture (Wauchope and Straus, 1987). Their analysis of parental self reports indicates that "minor violence" ("corporal punishment" generally accepted as non-abusive within American communities) reaches 20% prevalence in the first year of life, peaks at 90% by age three and declines to approximately 15% by age 17. Thus, minor violence is normative for young children and increasingly deviant after age 13, when less than 50% of parents admit to the acts of minor violence included in the Straus-Gelles scale (i.e., "threw something," "pushed/grabbed/shoved," and "slapped/spanked").

A generally similar trend is observed for "severe" violence, which includes "kicked/bit/hit with fist," "hit, tried to hit with something," "beat up," "burned or scalded," "threatened with gun or knife," and "used gun or knife." Severe violence stands at 5% in the first year of life, peaks age six (at 16%), and reaches its low point again (6.5%) at age 17. When "hit or tried to hit with something" is removed from the scale (in response to the normative character of this particular form of assault in many communities) there is no age trend observed in the data -- prevalence is about 2-4% throughout childhood and adolescence. This account of parental self-reporting on the use of violence with children and youth provides the backdrop for examining cases of physical abuse "diagnosed" by professionals and others outside the family (although it does not shed light of sexual abuse, neglect, and psychological maltreatment).

The National Incidence Study indicates that despite public and professional emphasis on child abuse and neglect, adolescent maltreatment accounts for a large proportion of all instances. In the 1980 data, the figure was 47% of the known cases of maltreatment (all forms). Teenagers accounted for 38% of the population under the age of 18. The American Humane Association cites adolescents as victims in 24% of all reported cases of maltreatment. This discrepancy arises from the fact that adolescent cases are less likely to be reported to protective service agencies than are cases involving children, and are more likely to be handled outside the protective service system by other agencies (where the NIS sampled; while the AHA did not).

An analysis of adolescent maltreatment rates that are confined to specific localities report findings somewhere between the National Incidence Study --i.e., 47%-- and the American Humane Association figures--i.e., 24% (Morgan, 1977). This seems to derive from differences in local reporting and definitional practices, as well as from differences in the composition of the populations included. That is, some jurisdictions screen out adolescents from the caseload, and the socioeconomic and demographic character of a community can affect the proportion of adolescents in CPS caseloads.

Using the original definitions employed in the 1980 study National Incidence, the overall rates (for both the 1980 and 1985) for cases of maltreatment known to professionals (protective services or in other agencies) are as follows for the six age categories reported:

All Maltreatment (per 1000 children)

	1980	1985
Age:		
0-2	6	6
3-5	6	10
6-8	11	15
9-11	11	15
12-14	12	23
15-17	14	28

Rates of various forms of abuse and neglect are reported in Figures 1-3. They parallel the overall trend closely, i.e., rates per 1000 that increase with age of victim. Figure 4 offers a comparison of rates by age for the first and second National Incidence Studies.

---Figures 1-4 here---

Community studies of adolescent maltreatment indicate similar patterns -- particularly if they are conducted in areas with active child protective services agencies that are sympathetic to adolescent victims or include other agencies (i.e., beyond child protective services) for case identification. For example, Blum and Runyan (1980) reported that 42% of all confirmed cases of maltreatment in Minnesota involved adolescent victims. Minnesota is a state with relatively little of the extreme poverty that tends to be associated with maltreatment (particularly neglect) in early childhood, and has been a leader in promoting professional awareness of adolescent maltreatment. In contrast to the Minnesota study, an intensive study of maltreatment rates in inner city Chicago neighborhoods where poverty is a major problem and there is little leadership in dealing with adolescent maltreatment (Garbarino and Kostelny, 1989) revealed a different picture:

Incidence of Maltreatment per 100 Children and Youth
(Area I poverty rate is 51%; Area II is 40%)

	Physical Abuse		Neglect		Sexual Abuse	
	Area I	II	Area I	II	Area I	II
Age:						

0-4	5.1	3.8	40.0	32.8	1.6	1.7
5-9	5.2	4.6	22.3	22.5	.7	1.8
10-14	2.4	1.8	10.8	13.5	.5	1.9
15-19	1.5	1.8	3.9	4.6	1.0	.1

The 1985 Incidence study offers breakdowns by age and type of maltreatment: adolescents receive less severe physical injuries and experience more psychological maltreatment, and more sexual abuse than do youngsters. The National Incidence Study reported that physical assault constitutes a smaller proportion of cases (42% vs. 52%) while psychological abuse accounts for a larger proportion (32% for adolescents versus 25% for children). These findings are supported in smaller clinical studies. For example, Berdie and her colleagues (Berdie and Wexler, 1984) reported that 68% of their sample of abused adolescents suffered emotional maltreatment, while 54% experienced physical abuse, 35% experienced neglect, and 24% experienced sexual abuse (percentages total more than 100% because of multiple occurence of maltreatment).

These sub-analyses generally parallel the overall trend for maltreatment as a whole. The major discrepancy is that the fatality rate declines with age (i.e., from .09 per 100 0-2 year old children to less than .01 per 1000 adolescents). However, a full accounting of the adolescent fatalities attributable to maltreatment could reasonably include numerous suicides and other self-destructive behavior appropriately linked dynamically and developmentally to the experience of maltreatment. For example, a runaway who leaves home to escape abuse and then falls prey to AIDS, or is murdered, or becomes suicidal on the streets is, in a very real sense, an "adolescent maltreatment fatality."

The National Incidence Study reports the following data to illustrate the point that other agencies beyond protective service agencies are dealing with the bulk of the adolescent maltreatment case load.

Percentage of Cases Known to Various Agencies
(1979 National Incidence Study)

Of all cases reported to:

Percent that are:	CPS	Other Investigation	Other Agency
0-5 years of age	41%	32%	8%
6-11 years of age	33%	12%	42%
12-17 years of age	35%	69%	50%

Two thirds of the cases known to "other investigation" agencies (but not CPS) are adolescents. Half the cases known to "other agencies" (but not CPS) are adolescents. The National Incidence Study report concludes: "the child's age may be a major determinant of whether or not a recognized maltreatment problem is reported to CPS for investigation and treatment. (p. 39)

Much of the existing body of research on abuse and neglect is based on hospital and protective service samples.

This has biased designs and findings against adolescent victims, who are less likely to be identified and served by these agencies. It leads to a concern that intervention models based upon these studies may not be generalizable across the full range of adolescent maltreatment cases. The National Incidence Study data reported earlier on the tendency of adolescent abuse cases to be less likely to be reported to the protective services system than were cases involving abuse of other age groups seems to justify such concern. An analysis conducted by the American Humane Association (Trainor, 1984), indicates, however, that the likelihood that adolescents will receive services once reported to protective services rose as professional awareness of the problem grew (from 33% receiving services in 1976 to 55% in 1982). The period 1976-1982 was a period of federally funded actions aimed at increasing professional awareness of adolescent maltreatment (cf., NCCAN, 1981; 1984).

Adolescent maltreatment tends to be associated with problematic acting-out behavior by the teenager or dysfunction within the family, and to be dealt with as such by agencies other than protective services. These maltreatment cases may often be buried under the labels of "dysfunctional families," "school adjustment problems," "running away," "acting-out," or "marital problems." Farber and his colleagues (Farber et al., 1984) administered a standard questionaire for assessing the presence of violence in the home (the Conflict Tactics Scale used by Straus and Gelles in their surveys of domestic violence) to two groups of adolescents. One group was made up of clients of a runaway program, while the other was composed of clients of the local protective services unit. The "runaways" and the "abuse victims" were not significantly different in their abuse scores; both were experiencing significant maltreatment.

This has implications for sampling in studying adolescent maltreatment as well as for policies and practices designed to prevent it. It indicates that all youth serving agencies dealing with "problem adolescents" are de facto part of the protective services system in the sense that they receive their clients from the same pool of youth in trouble.

Some gender differences are evident in the data on adolescent maltreatment. Females appear to be more likely to be abused as they pass through adolescence than in childhood, while risk for males peaks early and generally declines through adolescence. The National Incidence Study identified two female adolescent maltreatment victims for every one male (Olson and Holmes, 1983).

Small studies tend to confirm this, with the reported figures for percent female in the sample ranging from 55% (Garbarino, Schellenbach and Sebes, 1984) to 77% (Lourie, 1977). Powers and Eckenrode's (1988) analysis of New York State data found that among the 12-17 year olds, females accounted for 65% of the physical abuse cases reported, 88% of the sexual abuse cases reported, and 54% of the neglect cases reported. There are few exceptions to the general pattern of finding a disproportionate number of female victims in adolescence. One is the 45% female figure in the Pelcovitz study (1984).

One of the major unresolved issues about adolescent maltreatment concerns its relation to child abuse. As was noted earlier, it is rare that maltreatment occurs in a well functioning family. Almost by definition, maltreatment is a symptom of a larger family problem. Nonetheless, some students of the phenomenon have suggested that while some cases of adolescent maltreatment are simply a continuation of abuse and neglect begun in childhood, others represent the deterioration of unwise childhood patterns or the inability of a family that functioned reasonably well in childhood to meet new challenges in adolescence (Anderson, 1984; Garbarino, 1980). This latter category might be construed as a situation in which adolescence brought to fruition a vulnerability in the family system that had gone untested during childhood. Because during childhood the parents are able to preempt family crisis through their superior power, they may be unable to respond effectively when this a capcity is overcome during adolescence.

The relative proportion of adolescent maltreatment cases in the two categories (i.e., child vs. adolescent onset) varies from study to study (based in part, it seems, on difference in definition and/or sampling). Lourie (1977) concluded that 90% of adolescent abuse cases begin in adolescence. In Libby and Bybee's study (1979) 80% were so described. Garbarino and Gilliam (1980) report a 50-50 split. Pelcovitz (1984) reports 57% adolescent onset.

Farber and Joseph (1986) report that 29% displayed adolescent onset, while 51% began in childhood but became qualitatively more severe in adolescence. They report that 21% were severe through childhood into adolescence. Berdie and her colleagues concluded that 24% of their adolescent cases began in adolescence (1983; 1984). Taken together, the existing studies suggest that there is a distinctly adolescent genesis in a significant number of adolescent maltreatment cases.

Most of the studies noted above deal either with the full range of maltreatment (i.e., physical, sexual, psychological) or concentrate on physical abuse. What about sexual abuse, where there is a presumption that the dynamics differ somewhat from those governing physical abuse and psychological maltreatment (Finkelhor, 1979; 1984; Garbarino, Guttmann, and Seeley, 1986)?

Most studies indicate that sexual abuse begins in childhood, before the onset of adolescence. Kendall-Tackett and Simon (1988) conducted an interview study with adults who had been victims of sexual abuse, to assess the likelihood that the onset and termination of sexual abuse are related to puberty. They interviewed 365 adults. The average age of onset reported retrospectively was 7.5 (with less than 10% having an onset after age 12). In less than half of the cases did sexual abuse continue past the age of 12. The actual dynamics underlying this finding are open to informed speculation, for no clear evidence has been presented to document them. As the authors note, "As the victims approached adolescence, they, for the fist time may have become fully aware of the implications of the sexual activity."(pp 78-79) Also, the greater resources of the adolescent (including both peer relations and individual power) may equip the adolescent to terminate the sexual abuse by threatening exposure of the perpetrator or even physical retaliation. Another reason for this finding may be that many "fixated" sexual abusers lose interest in their victims when they begin to lose prepubescent physical attributes. It is their physical (and psychological) immaturity that is sexually attractive in the first place to the fixated sex abuser.

Most studies comment upon the aversive and/or dysfunctional character of the adolescent victim of maltreatment. Libby and Bybee (1979) report that in more than 90% of the cases they studied, specific abusive incidents were preceded by negative adolescent behavior (such as disobeying or arguing). Was this negative behavior the result of earlier maltreatment? The studies do not provide clear evidence on this score. None offers the kind of prospective, longitudinal design that would be necessary.

Certainly we can say that in a general way parents are responsible for the outcomes evidenced by their children. However, it is undeniable that maltreatment is not the sole source of problematic development in children. Temperamental problems, parent-child mismatches, negative extrafamilial influences, and genetic predisposition to pathology all play a role. Although we cannot be confident about the pattern of causation, the pattern of association is evident: preventing adolescent maltreatment involves helping parents (and other adults) work effectively and non-abusively with troubled and troublesome teenagers. While this seems self-evident, it is a condition that goes unmet daily in homes and institutions in which parents and other adults respond punitively to troublesome adolescents in the mistaken belief that they suffer from a deficit of punishment. Indeed, one can say with some confidence that youth who have been subjected to maltreatment have less capacity to cope with inadequate care than do other youth. In general, youth who have been treated well have greater reserves of self-esteem and adaptability, and thus can adapt better to less than optimal care.

Berdie and her colleagues (1983) report that 49% of their adolescent maltreatment victims exhibited significant clinical indicators of depression. Between 45-70% of the adolescents manifested problems such as nervous habits, isolation, poor social skills with peers, lethargy, low self-esteem; low frustration tolerance, temper outbursts, and stubbornness.

Garbarino and his colleagues (1986) used a standard checklist of behavioral problems and psychopathology (the Achenbach Child Behavior Checklist) to assess the presence of problems in abused adolescents. They selected a sample to maximize the presence of such problems: the overall group's score is at the 85th percentile on such problems. The important finding lies in the contrast between maltreated and non-maltreated youth. The abused group was significantly more problem-ridden (the 90th versus the 80th percentiles): evidencing between 50% and 100% more problems (depending upon the type of problems being considered and the source of the report). The difference was greater for acting out behavior such as aggression, obnoxious social behavior, and truancy ("externalizing" problems), than for problems of feelings and self image such as somatic complaints, obsessive-compulsive behavior, and withdrawal ("internalizing" problems).

Programming and policy aimed at adolescent maltreatment should be a high priority for institutions serving adolescents who evidence developmental problems. Youth who evidence developmental problems and who have experienced maltreatment constitute the principal high-risk group to be targeted for preventive and protective intervention (West, 1989). Federal policy and programming should seek to stimulate movement towards this goal.

One common problem found in dealing with maltreated adolescents is that they are often simultaneously classified as both victims and perpetrators. For example, the youth who is detected as sex offender against a child is discovered to have been a victim of sexual abuse (West, 1989). This is a particular problem since it generates ambivalence about adolescent victimization and may be seen to justify punitive approaches when in fact therapeutic approaches are desperately appropiate to deal with the consequences of adolescent maltreatment.

III. CONSEQUENCES OF ADOLESCENT MALTREATMENT

The consequences of child maltreatment include injuries that impair psychological and physical development, and in the extreme that result in death. The direct developmental consequences of child abuse include the likelihood of insecure attachment relations, dysfunctional peer relations, lower self-esteem, both internalized and externalized problem behavior and psychopathology, and intergenerational risk of abusing children in the next generation (Youngblade and Belsky, in press). And, of course, one consequences of being an abused child is the probability of becoming an abused adolescent.

When it comes to specifying consequences specific to adolescent maltreatment (as differentiated from child maltreatment) we have no such body of evidence. Most discussions of this issue focus on whether maltreatment observed during adolescence is simply a continuation of a pattern begun in childhood or represents something that has its onset during adolescence. Informal discussions with professionals in the field (at conferences, seminars, consulations and other settings) suggest that they tend to believe that if adolescent maltreatment cases are simply chronic child maltreatment cases that have gone unsolved, then the effects are related to the continuation of childhood problems. They say this with the recognition that there often is an intensification of the childhood problems that occurs in adolescence. If the majority of adolescent cases are indeed continuation of child maltreatment cases (using the conclusions of Berdie and her colleagues as a guide-- 1984), then the "consequences of child maltreatment" research is our best guide.

As noted earlier, most observers have concluded that adolescence typically intensifies and makes more dramatically visible psychological and social problems and characteristics that arose during childhood (Ebata, 1986). In contrast, the adolescent onset case is presumed to offer an individual who has had a extensive experience of non abusive treatment in the family, and thus may be expected to have positive psychological momentum (i.e., intact attachment, adequate peer relations, adequate self-esteem, etc.).

Thus, we would expect that the consequences of being maltreated in adolescence depend upon whether we are considering a case of adolescent onset of maltreatment or simply encountering a case of chronic child abuse. The former (adolescent onset) tends to offer a better prognosis than the latter (chronic child maltreatment that continues into adolescence). Better prognosis here refers to eventual restoration of the family system to equilibrium, and less pathology and problem behavior on the part of the adolescent.

Research has not addressed this issue directly. However, it is possible to offer some informed speculation based upon the results of studies which have examined the differential impact of trauma in cases of childhood versus adolescent onset. For example, Elder's studies of children and youth who were subjected to the trauma of family income loss during the Great Depression of the 1930's (e.g., Elder, 1989) demonstrate that those who were young children when the Depression hit their families were more adversely affected than were those who were adolescents when the economic trauma hit. What is more, this effect was most strongly evident for families with a pre-Depression history of marital discord and in which fathers responded by becoming highly punative and nasty as a reaction to unemployment. This line of collateral research appears to be consistent with the early vs. late onset of maltreatment hypothesis.

Galambos and Dixon (1984) adopted this approach in their analysis of adolescent maltreatment and the development of personal sense of control (which did not include data specifically collected to test hypotheses).

Their conclusion is that adolescent onset cases will display greater sense of internal locus of control (i.e., greater sense of personal self control) by virtue of their non-abusive childhood and the correspondingly shorter duration of their abuse. It is presumably for this reason that informal discussions with clinicians often reveal the belief that adolescent onset cases are easier to deal with because the victim has personal resources to mobilize during the intervention (in contrast to the chronic child abuse case in which the long history of deprivation and victimization leaves much less for the clinician to work with). But this speculation, however well grounded, still requires empirical test.

The coincidence of maltreatment with many youth problems noted earlier bears on the topic of consequences, of course. To some degree, this coincidence reflects a causal relationship (e.g., sexually abused kids run away from home-- McCormack, Janus, and Burgess, 1986). To some degree, it may represent the operation of some third factor (e.g. the same kinds of families that abuse kids also push them out of the home onto the streets).

Which youth problems are correlated with maltreatment? Most. Running away is one. For example, McCormack, Janus, and Burgess (1986) report that 73% of the female runaways and 38% of the male runaways they studied cited having been sexually abused as a cause of running away. Delinquency is another. A review (Garbarino and Plantz, 1986) concludes that child maltreatment (particularly when defined broadly) is associated with juvenile delinquency (particuarly when defined narrowly as violent anti-social behavior). Most of this evidence is not specifically concerned with adolescent maltreatment, however. Rather, it deals with child maltreatment that eventuates in adolescent problems. Thus, for example, it is not until adolescence that sexually abused kids run away, until adolescence that physically abused kids act out with sufficient social impact to warrant the charge of delinquency, and emotionally tortured kids engage in dangerously self-destructive behavior involving drugs.

IV. ADOLESCENT MALTREATMENT IN THE CONTEXT OF DOMESTIC VIOLENCE

The risk of a child being abused increases proportionately to the degree and severity of assault between that child's parents (Straus and Gelles, 1988). Beyond acknolwedging that link, our task here is to examine the special links between various forms of domestic violence as they affect and involve adolescents.

One evidence of the greater power of abused teens and wives -- compared to abused children --is the fact that they sometimes are involved in reciprocal assault (c.f. Browne, 1987; Post, 1982). Obviously, children and elderly individuals cannot match the strength of the parental generation, but abuse has been identified as a contributing factor in many assaults by adolescents, from relatively minor incidents to parricide (Garbarino and Gilliam, 1980). Wives who kill their husbands and adolescents who kill their parents often do so in retaliation for abuse, usually as the culmination of a long period of mutual assault in which wives are the chronic losers. Straus, Gelles, and Steinmetz (1980) reported assault by youth against their parents in some 10 percent of American families.

The parallels between adolescent and wife abuse extends beyond these power dynamics, of course. The two groups are likely to face similar psychodynamic issues, including ambivalence about dependency and separation in their relationships with family authority figures. For example, both may engage in repeated attempts to flee the home, only to return when the challenges of independent living and/or the pain of separation is too great (Gelles and Straus, 1988; Garbarino, Schellenbach, and Sebes, 1986).

V. RISK FACTORS

Developmental shifts and changes in social expectations for caregiving and socialization come together to shift the standards which guide appropriate behavior in family relationships when a child reaches adolescence. Some forms of behavior by parents toward their offspring which were socially acceptable (if not particularly wise) in childhood may become abusive in adolescence. For example, the psychological connotations and behavioral response to spanking a three- or four-year old ("control through force") are usually different from those of spanking a 15-year old. This is evident in the trends in parental use of physical punishment noted earlier: 90% of parents use it with three year olds while by age 15 this has decreased to 35% (Wauchope and Straus, 1987).

Likewise, a permissive policy of "control through indulgence" that is possible in response to the child's relatively benign impulses may become untenable in adolescence, for even the most permissive parent cannot fully indulge the more powerful impulses of the adolescent. Also, managing every detail of a four-year old's daily existence ("control through intrusion") may be acceptable, while the same intrusiveness with a teenager would be entirely inappropriate and likely to produce a strong adverse reaction leading to family conflict.

This is crucial because observational research (Reid, 1986) shows that abusive families are behaviorally differentiated from non-abusive families mainly in their handling of the 5-10% of parent-child interactions that are negative. Non-abusive families are able to conclude (or at least terminate) these negative interactions quickly. Abusive families are ineffective, and become enmeshed in escalating conflict. It is possible that some of the families using the strategies enumerated earlier (control through force, indulgence, or intrusion) become abusive in adolescence because these approaches are no longer sufficient to prevent or put the lid on negative exchanges and prevent the escalation of conflict. This implies that parent education programs should encourage parents to adopt a truly developmental perspective --i.e., evaluate child rearing practices in light of their eventual impact on the adolescents those children will become.

Adolescents typically demand a more nearly equal role in family decision-making (Steinberg and Hill, 1980). Observational research presents a picture of the youth challenging the parents (particularly the father) for a more active role in leading family discussions and decision-making (Steinberg and Hill, 1980).

What does adolescence mean for the family as a whole? For one thing, it means adjusting patterns of authority and interaction to incorporate a new person. Developmental psychologist John Hill (1980) looked at the research on this matter, and he concluded that:

> Studies where family interaction is directly observed suggest that there may be a period of temporary disequilibrium in early adolescence while the family adjusts to having a "new person" in the household--"new" in stature, "new" in approaching reproductive capability, "new" in cognitive competence--but this disequilibrium in no way approaches the shoot-out that many parents are led to expect from media reports. Instead, in most families, there appears to be a period of adaptation to the primary changes, a period when

> both parents and their newly adolescent children work out--often not consciously--what these changes mean for their relationships. (1980, p. 33)

At its heart, the task of being parent to an adolescent (and adolescent to a parent) is substantially different from the parent-child relationship, in ways which have implications for preventing adolescent maltreatment (Garbarino & Gilliam, 1980; Garbarino, Schellenbach, Sebes, and Associates, 1986).

The adolescent's power is much greater than the child's. This includes physical power, of course, including the capability for physical retaliation if assaulted by a parent. The adolescent requires a reorganization of family roles. The enhanced power that comes with adolescence accompanies the need to redefine family roles, and is often a destabilizing force, particularly when parents and/or adolescents have little motive or facility for flexible negotiation and compromise. These changes in power and role set in motion challenges to the family.

Unlike families at high-risk for *child* maltreatment, families at high-risk for destructive parent-adolescent relations are not so heavily concentrated among the families living in poverty (Garbarino, Schellenbach, and Sebes, 1986). The big social class differences that characterize *child* maltreatment cases are attenuated in the case of adolescent maltreatment. This is evident in the National Incidence Study. Adolescent abuse families were half as likely as child maltreatment cases to be poor (i.e., earning less than $7,000 per year in 1979 dollars). Nonetheless, 66% of the adolescent maltreatment cases had family incomes below $15,000 in 1979 dollars --with 25% below $7,000 and 33% above $15,000 (National Center on Child Abuse, 1980). Presumably, some of the observed attenuation of social class differences in adolescence is attributable to the fact that parents tend to be older, and thus earning higher wages than the (on average) younger parents of child abuse victims.

Berdie and colleagues (1983) reported that about 51% of the families in her study earned less than $15,000 at a time when approximately 20% of all families did so. Garbarino and Gilliam (1980) reported findings consistent with the National Incidence Study. What is more, when they compared adolescent onset cases with childhood onset adolescent maltreatment cases, they found even more striking differences. The adolescent onset cases were about half as likely to be in the poverty group as the child onset (and child maltreatment) cases. This finding is particularly important since it weakens the argument that the observed higher social class of adolescent maltreatment cases is simply the result of the parents of adolescents being older. The comparision of the adolescent onset with child onset adolescent maltreatment cases revealed no significiant difference in parental age.

In the protective service-based sample, adolescent onset families were four times as likely to have incomes in excess of $11,000 (in 1978 dollars): 42% versus 11%. Garbarino and colleagues (1984) report no difference in family income between families judged to be abusive and families judged non-abusive; about half of each group of families have incomes of nearly $20,000 (in 1982 dollars). This finding suggests that the attenuation of social class differences in comparing child and adolescent abuse cases is not simply an artifact associated with parental age. Rather, it reflects a real difference in the relevance of social class to parenting dysfunction associated with child age.

Despite the finding that family income is not a powerful predictor of risk for adolescent maltreatment, some research does suggest that a feeling of deprivation and strained resources associated with larger family size may play a role (Vondra, 1986).

Several studies have used measures of social class that are not based on income. The National Incidence Study reports higher educational levels for parents of maltreated adolescents than maltreated children. Farber and Joseph (1986) report that their families were predominantly lower class (average Hollingshead Index of 53). Pelcovitz and his colleagues (1984) report that 59% of their families were classified in the two top socioeconomic groups (five-point Hollingshead Index). Libby and Bybee (1979) indicate that only 12% of their families were located in the lowest (of eight) socioeconomic status categories. Garbarino and his colleagues (1984) report no difference between families judged to be abusive and comparable non-abusive families on a Hollingshead Index.

Families at high-risk for maltreatment in adolescence are more likely to contain stepparents. A variety of analyses point to the stepparent-adolescent relationship as a very risky one, particularly among families in which adolescents exhibit developmental pathology (e.g., Kalter, 1977; Daly and Wilson, 1981). Studies of maltreatment tends to confirm this. Overall, demographers estimate that about 11% of all adolescents live in step families (Mikesell and Garbarino, 1986).

Libby and Bybee (1979) reported that 28% of their families were stepfamilies; an additional 8% were adoptive. Berdie and colleagues (1983) reported that 25% of their families were step, and 31% had no father-figure in the home. Olson and Holmes' (1983) analysis of data from the National Incidence Study revealed that 40% of the adolescent maltreatment cases contained a step-parent.

Garbarino and colleagues (1984) found that among a sample of youth identified as "having problems" by professional nomination, 41% of the step families were judged to be abusive by the interviewers who reviewed the available evidence concerning the family. In contrast, none of the step-families included in the study through this nomination procedure was judged to be non-abusive. "Having problems" was defined to the professionals doing the nomination as "a youth who is experiencing significant difficulties as evidenced by repeated expressions of concern by parents or teachers, referral to mental health services, police contacts, or other indications of major concern about the youth's behavior or development." Farber and Joseph (1986) reported that only 30% of their adolescents were living with both biological parents.

Families characterized as high-risk for adolescent maltreatment reveal a general pattern of difficulty in relating as an interpersonal system. They are at high-risk on the dimensions of adaptability, cohesion, support, discipline, and interparental conflict. Pelcovitz and colleagues (1984) conducted a clinical analysis of their 22 adolescent physical abuse families. They classified cases into childhood- and adolescent-onset. The eight childhood-onset families (14 adolescents) were characterized in the multi-problem child abuse mode. That is, they manifested intergenerational abuse, spouse abuse, and developmentally inappropriate demands, all the elements of what Helfer and Kempe (1976) term "the world of abnormal rearing." The 14 adolescent onset families (19 adolescents) fell into two categories on the basis of multiple, independent clinical assessments: seven "authoritarian" and seven "overindulgent."

The authoritarian families were characterized by paternalistic, harsh, rigid, domineering styles of childrearing (Pelcovitz et al., 1984). This was coupled with denial of parental feelings toward each other and about the family system. Abuse typically arose from adolescent challenge (acting out and testing behavior) that was met with overwhelming force. The high priority placed upon control provided the foundation for high levels of force.

In contrast, the overindulgent families were characterized by parental efforts to compensate for the emotional deprivation that they had experienced in their own childhood (12 of the 14 parents had lost one or both of their parents during childhood). These families made few demands upon their children, set few limits, and desired a high level of emotional gratification from them. When the children reached adolescence and sought to form primary attachments outside the home or began to act impulsively in important social settings the overindulgent parents reacted with excessive force.

Garbarino and his colleagues (1986) have contrasted the family system of families judged to be abusive with that of families judged to be non-abusive. They used an assessment of family adaptability and cohesion (FACES) to assess the overall interaction. Abusive families tended to score in the "chaotic" and "enmeshed" categories (on adaptability and cohesion, respectively). Non-abusive families scored lower on these scales, putting them in the more normal "flexible" and "connected" range. On a measure of inter-parental conflict, adolescents in the abusive families tended to rate their parents as evidencing more conflict. However, the average difference masks the fact that some abusive families evidenced extremely high conflict while others evidenced extremely low conflict. This pattern was evident in a two year follow-up in which it appeared that some families dealt with conflict by expelling the adolescent, while others simply suppressed all manifestations of conflict through a conspiracy of silence.

VI. PREVENTION AND INTERVENTION

What do we know about preventing adolescent maltreatment? In one sense, we know a great deal. To the degree that we are successful in preventing child maltreatment we will have gone a long way towards preventing adolescent maltreatment. If the estimate that 50% of the adolescent maltreatment cases are "adolescent onset" cases is correct, then prevention efforts aimed at childhood are certainly a good investment (as a successful child abuse intervention programs that short circuit the process through which about half of the adolescent maltreatment cases arise -- i.e. as unresolved child abuse cases).

Child maltreatment is preventable through a combination of several strategies (Daro, 1989; Garbarino, 1986). These include: home health visitor programs that start prenatally and continue through the first years of life (particularly for high risk families), parent education and support programs, efforts to decrease the overall level of violence in American life, and public awareness programs that raise the standard of care for children.

Adolescent maltreatment prevention programs aimed at the half of the cases that are distinctly adolescent in origin are less well understood. Based on what has been learned, however, it seems clear that such efforts must include conflict resolution skills for parents and kids, improved knowledge for both parents and kids about the normal sources of conflict in adolescence, and the availability of counselling resources for kids and parents at risk, as they enter adolescent and may begin to encounter the fruits of unwise child rearing strategies. Of course, parent eduction in early childhood to prevent adoption of unwise child-rearing strategies is itself an important way to prevent adolescent maltreatment in the long run.

Practitioners have long recognized that the service needs of children and adults differ markedly. These differences emerge with respect to issues of informed consent, placement, verbally-mediated therapy, and other aspects of intervention (West, 1989). Placing adolescents on this continuum of maturity has proven even more difficult. As one review concludes: "Not only is the adolescent's position paradoxical, but institutional reponses to adolescent needs and problems also have been ambivalent and paradoxical" (West and Stuart, 1989, p.62). This is particularly evident in our efforts to understand and deal with abuse and neglect. One role for federal activity can be to stimulate efforts to rationalize and systematize local and state efforts. NCCAN (The National

Center on Child Abuse and Neglect, located administratively within HHS) is the logical leader in such an effort given its mandate under the federal child abuse treatment and prevention legislation.

Most approaches to intervention differentiate between child abuse and spouse abuse. However, few researchers, practitioners, or policy makers have addressed the differences between child and adolescent maltreatment. However, we need a developmental perspective. Intervention strategies should reflect changes in the meaning, causes, correlates, and effects of mistreatment that exist because of development and maturation (Cicchetti and Rizley, 1981; Garbarino, Schellenbach and Sebes, 1986). Federal efforts in the 1970's to accomplish this goal (by funding reserach and demonstration projects dealing specifically with adolescent maltreatment) by NCCAN, NIMH, and the Youth Development Bureau were helpful, but need to be revived.

The issues for school-age children differ from those for infants, or even for three-year olds, for that matter. The infant is a perfect victim in two senses. First, the infant can do virtually nothing to protect itself from abuse and is totally defenseless against neglect. The battered baby is victimized in direct proportion to the parent's impulses and the presence of internal and external constraints (which are often few). The infant experiences neglect in exact proportion to the parent's failure to provide care, thus being liable to non-organic failure to thrive. What is more, the infant's capacity to signal its plight to others is limited and largely unconscious. On the other hand, the infant is perfectly blameless when victimized. There is no issue of culpability raised, as there often is when the victim of assault is a spouse or an adolescent.

One implication is that intervention for adolescents must include experiences designed to facilitate the victim's "processing" of their own contributions to maltreatment. Children too may need a treatment plan that includes this element, but they face an easier time of it socially in the sense that few adults are prepared to blame children for eliciting maltreatment in the same way that they are ready to do so with adolescents. Even when objectively blameless, the adolescent victim may feel or be made to feel that they have contributed to their situation. Adolescents do play a more active role in shaping the course of their experience of victimization.

In contrast to infants, school-age children have better resources. They can adapt to the parent to minimize abuse by assuming whatever role will appease the parent, e.g., by being extremely compliant, innocuous, or responsible. They can counteract neglect by fending for themselves to some degree. Their ability to communicate their plight is greater because of language skills, and attending school offers many opportunities to do so. Finally, they are likely to have larger independent social networks from which to draw nurturance, support, and protection. But, what they gain in power they lose in credibility as a victim.

This sort of developmental contrast is essential in assessing intervention strategies. It implies that many of the "empowering" strategies employed in intervention programs aimed at battered women may be applicable to programs dealing with maltreated youth. This may be one reason why many professionals favor the apporach of "alternative" youth agencies that focus on empowerment. Adolescent victims need to learn that they can and must "take charge" of their lives, cope with the strong ambivalence they may feel about their dependent relationships (i.e., with the parental perpetrator), and use what options they have to minimize victimization while making use of more positive relationships (e.g., with peers, postive kin, and other supportive adults).

There are few published reports of intervention efforts targeted specifically at adolescent maltreatment (cf., Gureney, 1986). None of these efforts includes a really satisfactory systematic evaluation of outcomes. A review of what programs are available indicates several conclusions worth noting here, however.

First, the association of adolescent maltreatment with other problems demands a multi-disciplinary team approach. For example, Flanzer and Sturkie (1987) explored the role of alcohol in adolescent maltreatment cases and a family services model used to respond. They concluded that "Family systems therapy tailored to working with abusive families succeeded in stopping abusive behavior, decreasing drinking behavior, decreasing feelings of depression and other clinical variables (particularly with physically abusive families)" (p. 84). Adolescent maltreatment confronts the helper with numerous "feedback loops" within the family system-- e.g., drinking disinhibits violence; the youth copes with feelings of victimization by resorting to alcohol use, which leads to more negative behavior which precipitates further abuse. A comprehensive settlement within the family is important.

Second, an important piece of the intervention strategy for dealing with adolescent maltreatment is to be found in the network of "alternative, community-based programs for youth" (Fisher and Berdie, 1978; Guerney, 1986). These agencies tend to respond in a generic way, rather than in the categorical manner often found in more traditional public and private agencies. The finding that runaways and diagnosed abuse victims may be more similar that not (Farber and Joseph, 1984) reinforces this proposition.

The ambiance and "institutional culture" of the "alternative" network agencies makes them attractive and accessible to youth. For this reason, one of the important intervention issues is the degree to which the formal protective services system can and does cooperate with the youth serving network agencies in serving victims of adolescent maltreatment. A related issue is the capacity and willingness of alternative youth serving agencies to deal with adolescent maltreatment issues.

Third, peer influences are an important consideration. Efforts to create formal peer helping programs have highlighted the need to be sure that such efforts have indigenous and widespread support among adolescent peer groups (Guerney, 1986). Efforts to train peer counselors and sustain their operation in the long run often prove difficult (Garbarino and Jacobson, 1978). Rather, the more fruitful course appears to be education of peers as a whole to serve as a referral source for teens to adults and to provide positive support for adolescent victims. This can be part of an effort that includes peer helping in a group setting, with appropriate adult leadership (Garbarino, 1980; Garbarino and Jacobson, 1978).

Fourth, sustained intervention can remediate many of the consequencs of abuse --particuarly sexual abuse -- _if_ the victim's primary relationships (to parents or permanent substitutes) are restored to "working order," and the victim receives intensive therapeutic and support services. For example, a U. S. Justice Department-sponsored study of a sexual abuse treatment program (the Family Crisis Program at Tufts University) found that 75% of the 4-13 year olds did not exhibit significant psychopathology when compared to other children of the same age who had not been sexually abused (Gomes-Schwartz and Horowitz, 1988). No data specifically addressing the adolescents in the sample are provided.

Intervention for cases of adolescent maltreatment is embedded in overall efforts to intervene with youth in trouble. There has been a substantial change in the past ten years in the awareness of adolescent maltreatment as a protective service issue -- with corresponding increases in the likelihood that a reported case will receive services (AHA, 1986). Nonetheless, the bulk of intervention conducted with and for adolescent maltreatment victims continues to occur outside the formal protective service system in the larger "youth services network." What is more, it appears that a significant proportion of this service occurs as a result of and through the youth's involvement in the juvenile justice, juvenile court, and family court systems (Garbarino, Schellenbach, and Sebes, 1986).

VII. POLICY

Adolescent maltreatment is most likely to arise when a troubled youth lives within a high-risk family. Like most social problems, the problem of adolescent maltreatment thus presents a self-fulfilling negative feedback loop. High risk parents are more likely to produce a family system that itself tends to be pathogenic. The result is a child who is unprepared to deal effectively with the challenge of adolescence. That same family system is unprepared to deal effectively with the developmental problems that result when that unprepared child faces adolescence. All this finds its most extreme form in the case of child abuse that goes unremediated.

Thus, we should direct our efforts towards identifying family patterns in childhood that bode ill for effective adjustment to adolescence. Untreated, chronic child maltreatment is a major problem, of course. But beyond child abuse stand "risky" childrearing patterns that appear to set the stage for adolescent maltreatment. Overindulgence and authoritarianism are the two patterns that appear most frequently in the existing research. As a matter of policy, parent education programs should seek to identify these high-risk patterns in childhood and redirect them toward more adaptive patterns that cast neither the child nor the parent in a dictatorial role, but rather establish norms and practices of reciprocal negotiation that evolve from appropriate use of parental authority. This will help to pave the way for an effective transition to adolescence. Video-taped presentations to all elementary schools parents would be one way to communicate this message efficiently.

In addition, intervention programs should focus upon the adolescent period itself. They should stress the normal demands for adaptation that adolescence brings for youth and adult alike. Effective conflict resolution and communication skills will provide the foundation for accomplishing this important process of adaptation and preventing the deterioration of parent-child relations that results in adolescent maltreatment. Once again, the time to start presenting this information is while the child is still in elementary school.

These then are the keys to preventing adolescent maltreatment: effective intervention in child abuse to stop developmental deterioration into adolescence, effective intervention with troubled adolescents to prevent them from exceeding parental coping capacity, and the promulgation of non-violent conflict resolution skills as part of a broad campaign to improve family functioning in adolescence.

This means that our preventive efforts must not be limited to programs and policies aimed exclusively at infancy and early childhood (where most attention has been focused-- Dubowitz, 1989). They should address the special issues that are involved in the transition from childhood to adolescence (e.g., negotiated role transitions in families). Thus, for example, the late elementary and early junior high school period is a high priority period for interventions that teach non-violent conflict resolution skills to both parents and youth.

The data suggest that special programming for adults and youth involved in step-family relationships is imperative. This is a high priority, particularly in cases where youths evidence disrupted psycho-social development before entering a step-arrangement. Indeed, what little research has addressed this matter at all suggests that it is the challenge of coping with a teen who is already at-risk because of prior disruption (e.g., divorce) that tends to precipitate maltreatment crises in step-families (e.g. Garbarino, Schellenbach, Sebes, and Associates, 1986) .

All this suggests the need for programs affiliated with schools, courts, clinics, and religious institutions aimed at adults and teens *before* they embark upon forming step-families. These programs should include information about the special challenges of step relationships to help adults and teens clarify roles. Offering strategies for non-violent conflict resolution shoud be one goal of such programs. Another should be to form consultative relationships between professionals and families prior to the onset of difficult,. Such relationships would then provide a resource for step-parents and adolescents if problems do arise. Such programming is particularly important in the case of kids who have exhibited difficulty adjusting to divorce and separation. Early risk predicts greater likelihood of problems in adolescence.

Conventional public welfare approaches aimed exclusively at *child* abuse are insufficient to deal with the *adolescent* maltreatment. A more broadly-based and community-oriented mental health approach is in order. Because of the weak relationship between social class and adolescent maltreatment (in contrast to the much stronger relationship existing between poverty and child maltreatment), the vast network of clinical service institutions that are regularly in contact with middle-class families (e.g., private therapists and residential institutions) must be drawn into efforts to deal with adolescent maltreatment. These include private clinics, schools, churches, and civic groups. Of course the good news here is that these families may have a good prognosis for responding to preventive programming.

Services that are attuned to adolescents (and particularly females) displaying "acting out" behavior (e.g. truancy, self-destructive behavior, and delinquency) must be especially vigilant for evidence of maltreatment. This evidence is to be found in direct and indirect reports by young people. For example, Farber and his colleagues (1984) used the Conflict Tactics Scale (cf., Straus, Gelles, and Steinmetz, 1980) as an instrument to detect maltreatment of adolescents in runaway shelters and other out-of-home sites. Many clinicians rely upon open-ended intake interviews for all adolescents receiving social, educational, or health services (physical and mental health).

Adolescents at high-risk for maltreatment tend to be less socially competent and exhibit more developmental problems than their peers. Therefore, prevention programs must respond to the additive and interactive nature of adolescent maltreatment (i.e., that adolescence may be precipitating and/or exacerbating patterns of difficulty rooted in childhood).

Although we cannot be confident about the pattern of causation, a pattern of association is evident, a pattern of association that directs our attention to improving parental ability to respond to troubled adolescents. Preventing adolescent maltreatment involves helping parents (and other adults) work effectively and non-abusively with troubled and troublesome teenagers. Families characterized as high-risk for adolescent maltreatment may also be at high-risk on the dimensions of adaptability, cohesion, support, discipline, and interparental conflict. Therefore, prevention programs aimed at adolescent maltreatment should adopt a broadly based approach to supporting and redirecting family systems. However, these programs should recognize that in some cases servicing the family may be untenable, and direct services to support the adolescent as an independent individual may be the most practical approach. As always when dealing with adolescent problems, we must accept the ambiguity that comes with the territory: intervention with adolescents involves charting a course through the difficult terrain between childhood and adulthood.

The role of the federal government in all this is to serve as a center of inspiration and coordination through the National Center on Child Abuse and Neglect. NCCAN should be the lead agency -- acting with the support and cooperation of the other units within HHS, the Department of Justice, and the Department of Education. The research and demonstration projects supported in the 1970's had a significant influence in stimulating professional understanding of adolescent maltreatment. Given the relative lack of attention to this issue in the last ten years, it seems appropriate that the federal government undertake a new initiative to consolidate knowledge and programming.

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